

Dear Oxford member,

Welcome, and thank you for selecting Oxford Health Plans.

At Oxford, your satisfaction is important to us, and we strive to help make your healthcare experience a positive one. As an Oxford member, you have access to a series of programs and resources to help you along your road to health.

Network access

We have a large network of hospitals and providers located throughout the tristate region.¹ Network doctors, mental health professionals, hospitals, clinics, and laboratories charge discounted rates, which typically save you money. If your plan offers out-of-area coverage, you may also have national network access outside of the Oxford tristate service area through the UnitedHealthcare Choice Plus or Core network, depending on your medical plan.²

Your personal member website

A self-service health plan member website allows you convenient, around-the-clock access to important information about your health benefits, the ability to request a health plan ID card, update your personal information, and more.

Rally®

Rally is a digital health and wellness experience built into your health plan member website that provides personalized lifestyle plans you can adopt as you work toward achieving and maintaining good health.

Sweat Equity Program

This wellness program offers you reimbursement toward your physical fitness expenses—up to \$200 two times per year—after meeting the program requirements.³

Cancer support

This program, led by experienced cancer nurses with assistance from a board-certified medical oncologist, a hematologist, and other doctors, as well as social workers, was created to support members who are affected by cancer. Call 1-866-936-6002 for support.

Centers of Excellence

For bariatric surgery and transplants, these providers are identified for meeting our quality assessment criteria and being in good standing with us and national accreditations.

Mental health and substance disorder services support

You have access to a 24/7 substance disorder services treatment help line, as well as a website dedicated to mental health and substance disorder services support. Call the Substance Use Disorder Helpline at 1-855-780-5955 24 hours a day, 7 days a week.

If you have questions about this information or your coverage, or if you want to learn more about available programs and resources, log in to your health plan member website or call Customer Service. The website address and our phone number are shown on your health plan ID card.

Wishing you the best of health,

The Oxford Team

¹ Tristate area includes Connecticut, New Jersey, and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau, and Suffolk). Network access may vary by plan.

² National network may not be available for all groups.

³ Reimbursement is generally limited to the lesser of \$200 (subscriber)/\$100 (covered spouse/partner) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. Refer to your benefits documents or check with your benefits administrator to find out how much you may be reimbursed. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. Oxford does not guarantee availability of programs in all service areas and provider participation may vary. Certain items may be excluded from coverage and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated.

The Centers of Excellence (COE) program providers and medical centers are independent contractors who render care and treatment to health plan members. The COE program does not provide direct health care services or practice medicine, and the COE providers and medical centers are solely responsible for medical judgments and related treatments. The COE program is not liable for any act or omission, including negligence, committed by any independent contracted health care professional or medical center.

UnitedHealthcare and Oxford do not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card 8 a.m. – 6 p.m. ET, Monday – Friday. TTY users can dial 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증

카드에 기재된 무료 회원 전화번호로 문의하십시오.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Administrative services provided by Oxford Health Plans LLC.

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Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to myuhc.com, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to myuhc.com or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.



Oxford Health Plans (CT), Inc.

Large Business Market

KACTOHPLiberty2021_03pdDR1

Schedule of Benefits

Tiered Network Plan

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|--|--------------------------------------|---|
| Plan Deductible Individual Family | \$2,500 per Covered Person. \$2,500 per Covered Person, not to exceed \$5,000 for all Covered Persons in a family. | | N/A |
| Separate Prescription Drug Deductible Individual | N/A | | N/A |
| Out-of-Pocket Maximum Individual Family (Includes deductibles, copays and coinsurance) | \$5,500 per Covered Person. \$5,500 per Covered Person, not to exceed \$11,000 for all Covered Persons in a family. | | N/A |
| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Provider Office Visits | | | |
| Adult/Pediatric Preventive Visits | N/A | No Cost | N/A |
| Primary Care Provider Office Visit (includes services for illness, injury, follow-up care and consultations) | No Cost | \$25 per visit | N/A |
| Specialists Office Visits | \$40 per visit | \$65 per visit | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|--|--|---|
| Mental Health and Substance Abuse Office Visits | N/A | No Cost | N/A |
| Outpatient Diagnostic Services | | | |
| <p>Advanced Radiology (CT/PET Scan, MRI)</p> <p>For Designated Network Benefits, services must be received from a Designated Diagnostic Provider.</p> <p>Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.</p> | <p>Designated Network</p> <p>N/A</p> | <p>Network</p> <p>Freestanding Facility: 10% per visit after INET deductible is met</p> <p>Hospital Based: 10% per visit after INET deductible is met</p> <p>Please refer to your provider directory to identify freestanding facilities and hospital-based facilities.</p> | N/A |
| <p>Laboratory Services</p> <p>Limited to 18 Presumptive Drug Tests per year.</p> <p>Limited to 18 Definitive Drug Tests per year.</p> <p>For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider.</p> <p>Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.</p> | <p>Designated Network</p> <p>10% per service after INET deductible is met</p> | <p>Network</p> <p>50% per service after INET deductible is met</p> | N/A |
| Non-Advanced Radiology (X-ray, Diagnostic) | N/A | 10% per service after INET deductible is met | N/A |
| <p>Mammography</p> <p>Ultrasound</p> <p>Please refer to the</p> | N/A | No Cost | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|---|---|---|
| Certificate for further information on this benefit coverage. | | | |
| Prescription Drugs – Retail Pharmacy (31 day supply per prescription) | | | |
| Tier 1 | N/A | \$5 copayment per prescription | N/A |
| Tier 2 | N/A | \$50 copayment per prescription | N/A |
| Tier 3 | N/A | 30% coinsurance up to \$500 maximum per prescription | N/A |
| Tier 4 | N/A | 50% coinsurance up to \$750 maximum per prescription | N/A |
| Prescription Drugs – Mail Order Pharmacy (90 day supply per prescription) | | | |
| Tier 1 | N/A | \$10 copayment per prescription | N/A |
| Tier 2 | N/A | \$100 copayment per prescription | N/A |
| Tier 3 | N/A | 30% coinsurance up to \$1,000 maximum per prescription | N/A |
| Tier 4 | N/A | 50% coinsurance up to \$1,500 maximum per prescription per prescription | N/A |
| Outpatient Rehabilitative and Habilitative Services | | | |
| Speech Therapy 60 visits per year limit combined for Rehabilitative (physical, speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, | N/A | \$30 per visit | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|---|--|---|
| physical and occupational therapies). | | | |
| Physical and Occupational Therapy 60 visits per year limit combined for Rehabilitative (physical, speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, physical and occupational therapies). | N/A | \$30 per visit | N/A |
| Other Services | | | |
| Chiropractic Services (up to 30 visits per year for Rehabilitative chiropractic services, separate 30 visits per year limit for Habilitative chiropractic services.) | \$40 per visit | \$65 per visit | N/A |
| Diabetic Equipment and Supplies For medically necessary covered insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$25 for an individual prescription of up to a 30-day supply. For medically necessary covered noninsulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$25 or an individual prescription of up to a 30-day supply. For medically necessary | N/A | Supplies obtained from your Physician are subject to the applicable Physician Cost Share. Supplies obtained through the pharmacy are subject to the applicable Pharmacy cost share based on Tier. | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|---|--|---|
| covered diabetes devices and diabetic ketoacidosis devices the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$100 for an individual prescription of up to a 30-day supply. | | | |
| Durable Medical Equipment (DME) | N/A | 10% per item after INET deductible is met | N/A |
| Home Health Care Services (up to 100 visits per year) | N/A | No Cost | N/A |
| Outpatient Services (in a hospital or ambulatory facility) | N/A | 10% per service after INET deductible is met | N/A |
| Prosthetic Services | N/A | 10% per item after INET deductible is met | N/A |
| Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all IP settings. (skilled nursing facility stay and inpatient rehabilitation is limited to 90 days per year combined) | N/A | 10% per admission after INET deductible is met | N/A |
| Emergency and Urgent Care | | | |
| Ambulance Services Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be | N/A | No Cost | Same as INET |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|--|---|
| <p>determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p> <p>Non-Emergency Ambulance</p> <p>Ground or Air Ambulance, as we determine appropriate.</p> <p>Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p> | | | |
| Emergency Room | N/A | \$300 per visit after INET deductible is met | Same as INET |
| Urgent Care Centers | N/A | \$75 per visit | N/A |

ADDITIONAL INFORMATION: MEDICAL SERVICES

What Will You Pay for Covered Health Care Services?

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Emergency Health Care Services – Outpatient

If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, 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.

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. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.

Benefit Limitations

The benefits listed below have the following limitations:

Outpatient Rehabilitation and Habilitative Services:

Post-Cochlear Implant Aural Therapy is limited to 60 visits per year for Rehabilitative post-cochlear implant aural therapy and a separate 60 visits per year limit for Habilitative.

Cognitive Therapy is limited to 60 visits per year for Rehabilitative cognitive therapy and a separate 60 visits per year for Habilitative.

Hearing aids

Hearing Aids will be covered once every 24 months.

The above limit does not apply to over-the-counter hearing aids. For over-the-counter hearing aids, Benefits are limited to \$1,000 every year. Benefits are further limited to a single purchase every year.

Fertility Preservation for Iatrogenic Infertility:

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.

Preimplantation Genetic Testing (PGT) and Related Services:

Benefit limits for related services will 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.

This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider*.

Accessing Benefits

You can choose to receive

Designated Network Benefits or Network Benefits.

Designated Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Care Services as identified in the *Schedule of Benefits* table above.

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

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 below

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?

In general health care terminology, prior authorization may also be referred to as precertification. We require prior authorization for certain Covered Health Care Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

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.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply.

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.

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) 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.

Allowed Amount

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

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***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*.

For Designated Network Benefits and Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and 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.

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 Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

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

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The provider may bill us directly and we will reimburse the provider the greatest of the following amounts:
- The amount we would pay for such services if rendered by an in-network health care provider;
- The usual, customary and reasonable rate for such services; or
- The amount Medicare would reimburse for such services.

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 will be covered the same as in-network.

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

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. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

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

If you are diagnosed with a condition or disease that requires specialty care and either we do not have a Network provider with the required specialty training or if access to a Network provider would require unreasonable travel or delay, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, you may contact us at the telephone number on your ID card, or your Network Physician can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network Physician to coordinate care through an out-of-Network provider. If your care is coordinated through an out-of-Network provider, Covered Health Care Services will be paid as Network Benefits.

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.

Dependent Age Limit

The Dependent age limit is 26. Coverage ends upon the Policy's anniversary date.

II. ADDITIONAL INFORMATION: OUTPATIENT PRESCRIPTION DRUGS

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Co-payments 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, however this does not apply to emergency contraceptives.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may

change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment 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.

Prescription Drug Tiers

Prescription Drug Products are categorized into cost tiers. Tier one contains lower cost generic drugs. Tier 2 contains preferred lower cost brand drugs. Tier 3 typically contains non-preferred brand drugs. Tier 4 typically contains higher cost brand drugs.

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.

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.

Prescription Drug Products which require prior notification are listed below.

Prescription Drug Products which require Notification: Absorica, Abstral, Actemra (subcutaneous formulation), Actimmune, Actiq, Adcirca, Adderall, Adderall XR, Adempas, Afinitor, Alecensa, Amitiza, Amnesteem, Ampyra, Aptiom, Arcalyst, Atralin, Aubagio, Avita, Avodart, Avonex, Banzel, Berinert, Betaseron, Bethkis, Bosulif, Brilinta, Bunavail, Caprelsa, Cayston, Cerdelga, Cholam, Cimzia, Cinryze, Claravis, Cometriq Compounds and Bulk Powders, Concerta, Copaxone, Cosentyx, Cotellic, Crinone, Cystaran, Daklinza, Daliresp, Daytrana, Desoxyn, Dexedreine, Dextrostat, Differin, Egrifta, Elidel, Eligard, Elocatate, Enbrel, Endometrin, Entresto, Epanova, Erivedge, Esbriet, Evekeo, Exjade, Extavia, Fabior, Farydak, Fentanyl citrate compounds, Fentora, Ferriprox, Firazyr, First Progesterone, Focalin, Focalin XR, Forteo, Fulyzaq, Fycompa, Gattex, Genotropin (excluded), Gilenya, Gilotrif, Gleevec, Grastek, H.P. Acthar, Harvoni, Hettlioz, Humatrope (excluded), Humira, Hycamtin, Ibrance, Iclusig, Imbruvica, Increlex, Infergen, Inlyta, Intron A, Iressa, Jadenu, Jakafi, Jublia, Juxtapid, Kalydeco, Kerydin, Keveyis, Kineret, Kitabis Pak, Korlym, Kuvan, Kynamro, Lazanda, Lenvima, Letairis, Linzess, Lonsurf, Lotronex, Lovaza, Lynparza, Mekinist, Metadate, Metadate CD, Metadate ER, Movantik, Multaq, Myalept, Myorisan, Natpara, Nexavar, Ninlaro, NordiFlex, Norditropin (excluded), Nutropin, Nutropin AQ, Nutropin AQ NuSpin, Nuvigil, Odomzo, OFEV, Olysio, Omnitrope (excluded), Omtryg, Onfi, Opsumit, Oralair, Orenzia (subcutaneous formulation), Orenitram, Orkambi, Otezla, Peg-Intron/Pegasys, Plegridy, Pomalyst, Potiga, Praluent, ProCentra, Procysbi, Promacta, Protopic, Porvigil, Pulmozyme, Quillivant XR, Ragwitek, Ravicti, Rebif, Rebif Rebidose, Rectiv, Regranex, Repatha, Restasis,

Retin-A, Retin-A Micro, Revatio, Revlimid, Ritalin, Ritalin LA, Ritalin SR, Ruconest, Saizen, Sandostatin/octreotide, Selzentry, Serostim, Signifor, Simponi, Sirturo, Solaraze, Sotret, Sovaldi, Sprycel, Stelara, Stivarga, Strensiq, Suboxone/Subutex, Subsys, Sutent, Sylatron, Syprine, Tafinlar, Tagrisso, Tarceva, Targretin, Tassigna, Tazorac, Tecfidera, Technivie, Temodar, Thalomid, TOBI, TOBI Podhaler, Tracleer, Tretinoin cream, Tretinoin gel, Tretin-X, Tykerb, Tyvaso, Upravi, Valchlor, Vascepa, Vecamyl, Ventavis, Victrelis, Viekira Pak, Vimpat, Votrient, Vyvanse, Xalkori, Xeljanz, Xtandi, Xyrem, Zelboraf, Zenatane, Zenzedi, Zomacton, Zontivity, Zorbitive, Zubsolv, Zydelig, Zykadia, Zytiga.

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 or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service, however a member has the right to file an appeal if a prescription drug product is determined not to be a covered health care 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 the *Outpatient Prescription Drug Rider* are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

This step therapy process will not require you to use an alternative brand name prescription drug or over-the-counter drug prior to using a brand name prescription drug that has been prescribed by a licensed physician for pain treatment. We may require you to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug. Step therapy is not required for a prescribed drug for cancer treatment for a Covered Person who has been diagnosed with state IV metastatic cancer when the prescribed drug is in compliance with approved federal Food and Drug Administration indications.

Prescription Drug Products subject to step therapy requirements: H.P. Acthar, Cystagon, Depakote, Depakote ER, Stavzor, Keppra, Keppra XR, Lamictal, Lamictal ODT, Lamictal XR, Lamotrigine ER, Lamotrigine ODT, Neurontin, Tomamax, Trileptal, Oxtellar XR, Qudexy XR, Zonegran, Trokendi XR,

Cialis (tadalafil) 2.5 & 5 mg, Bosulif, Sprycel, Xtandi, Amitiza, Brintellix, Fetzima, Inokana, Jardiance, Farxiga, Januvia, Janumet, Janument XR, Xigduo XR, Glyxambi, Trulicity, Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog Mix 70/30, Apidra, Apidra SoloStar, Afrezza, Oxistat, Jublia, Kerydin, Uloric, Nexium suspension (esomeprazole), Prevacid SoluTab (lansoprazole), Olysio, Sovaldi, Victrelis, Viekria Pak, Peg-Intron, Repatha, Lescol XL, Livalo, Stribild, Genvoya, Bravelle, Follistim AQ, Resulti, Rasuvo, Otrexup, Aubagio, Gilenya, Rebif, Rebif Rebidose, Extavia, Rescula, Travoprost (generic Travatan), Zioptan (tafluprost), Butrans, Embeda, Avinza, Exalgo, Hysingla, Kadian, MS Contin (Brand Only), Oxycontin, Oxymorphone hcl ER (generic Opana ER), Pancreaze, Pertzye, Ultresa, Viokace, Otezla, Xeljanz, Actemra, Orencia, Enbrel, Cosentyx, Lyrica, Cordran SP cream (flurandrenolide).05% cream), Cordran Lotion (flurandrenolide 0.05% lotion, Desonate (desonide 0.05% gel), Cloderm cream (clocortolone pivalate 0.1% cream), Halog cream (halcinonide 0.1%), Halog ointment (halcinonide 0.1% ointment), Soolantra, Belsomra, Rozerem, Zolpmist, Zovirax ointment.

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

What Do You Pay?

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Annual Deductible or Out-of-Pocket Limit.

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

- Ancillary Charges.
- 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.

Certificate of Coverage

Oxford Health Plans (CT), Inc.

This policy is intended to be federally tax qualified. Approval by the Insurance Department does not guarantee tax qualification and members and enrollees are encouraged to seek the counsel of a tax advisor.

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between Oxford Health Plans (CT), Inc. 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* if purchased by the Group.
- 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 Connecticut. The Policy is subject to the laws of the state of Connecticut and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Connecticut 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 Oxford Health Plans (CT), Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 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

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

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 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.

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. 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.

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.

Certificate of Coverage Table of Contents

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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 or are state/federally mandated:

- 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 requirements specified in the Policy.

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

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

1. Abortion Services

Benefits include services for a therapeutic abortion, that is an abortion recommended by a Provider performed to save the life or health of the mother, or as a result of incest or rape. The plan will also cover elective abortions.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the 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.

3. 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*.

4. 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.
- Disabling or life-threatening chronic disease.

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - 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 patient care costs are subject to the terms, conditions, restrictions, exclusions and limitations of this Policy. If treatment is not available at an in-network facility, coverage may be provided at an Out-of-network hospital at no greater cost than if such treatment was available in-network.

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 disabling or 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 disabling or life-threatening diseases or conditions. 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 disabling or life-threatening diseases or conditions, 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 disabling or life-threatening diseases or conditions. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)* .)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

5. Dental Services - Accident Only

Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair (not replacement) of sound natural teeth when both of the following are true:

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

Please note that dental damage that happens as a result of normal activities of daily living (such as biting or chewing) or intentional misuse 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 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 include the following:

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

6. Diabetes Services

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

Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes.

Coverage includes:

- Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to:
- Counseling in nutrition.
- The use of equipment and supplies
- Training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes.
- Training and education, up to four hours, because of the development of new techniques and treatments.

Diabetic Self-Management Items

Insulin pumps, supplies and medications for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps which are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment.
- Insulin.
- Oral agents such as glucose tablets and gels.
- Glucagon for use with injection to increase blood glucose concentration.
- Blood glucose meters including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

If your Benefit plan includes an *Outpatient Prescription Drug Rider*, Benefits for diabetic medications and supplies may be provided as described in the Outpatient Prescription Drugs section of the *Schedule of Benefits*.

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 *Devices, Appliances, Medical Equipment and Prosthetics*.

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

8. Emergency Health Care Services - Outpatient

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

Coverage includes Emergency Health Care Services due to accidental ingestion or consumption of a controlled drug. A "controlled drug" is a substance such as cocaine, morphine, hallucinogens, etc. It does not include alcohol, nicotine or caffeine.

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). This also includes coverage for isolation care and emergency services provided by the state's mobile field hospital.

Benefits do not include follow-up care provided in a Hospital Emergency room.

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions.

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.

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

12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed 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.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

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.

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

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

14. Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, or advanced practice registered nurse (APRN), or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available for:

- Part-time intermittent home nursing care by or supervised by a registered professional nurse.
- Part-time or intermittent home health aide services.
- Home Health Agency services include physical, occupational or speech therapy.
- Benefits are available for the following items to the extent that they would have been available if the Covered Person were confined to a Hospital:
- Medical supplies.
- Drugs and medicine.
- Laboratory services.
- Medical social services, including but not limited to those provided to or for the benefit of a Covered Person diagnosed by a Physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live. Medical social services are services, rendered under the direction of a Physician or an advanced practice registered nurse, by a qualified social worker. These services include, but are not limited to:
 - Assessment of the social, psychological and family problems related to or arising out of such Covered Person's illness and treatment.
 - Appropriate action and utilization of community resources to assist in resolving such problems.
 - Participation in the development of the overall plan of treatment for such Covered Person.
 - Continued care and treatment by an APRN and plan established and approved in writing by an APRN.

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 including radiologists, anesthesiologists, pathologists and Emergency room Physicians.

We will pay Benefits for an Inpatient Stay of at least 48 hours following a mastectomy or lymph node dissection. We will pay Benefits for a longer Inpatient Stay if it is recommended by the Physician after conferring with the patient.

17. Infertility Services

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

For the purpose of this benefit, infertility is defined as the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

Coverage must be provided for the expense for the diagnosis and treatment of infertility, including but not limited to:

- Ovulation induction.
- Intrauterine insemination.
- In-vitro fertilization.
- Uterine embryo lavage.
- Embryo transfer.
- Gamete intra-fallopian transfer (GIFT).
- Zygote intra-fallopian transfer (ZIFT).
- Low tubal ovum transfer.

Benefits for infertility include but are not limited to the following:

- Ovulation induction is limited to a maximum benefit of four cycles;
- Intrauterine insemination is limited to a maximum benefit of three cycles;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to a maximum of two cycles, with no more than two embryo implantations per cycle;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful;

Covered Health Care Services must be performed at facilities that conform to the standards of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

18. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Additional screenings and services to monitor for breast cancer and other gynecological cancers may be considered preventive care services under state law. When applicable, They are covered with no Copayments or Coinsurance, however your Deductible may apply.
- These may be available to you, if you are believed to be at an increased risk due to:
- A family history, or

- A prior personal history of breast, ovarian, or certain related cancers, or
- If the treatment of a childhood cancer has increased your risk of breast cancer, or
- A positive genetic test for gene variants that increase your risk to certain cancers, or
- Other indications as determined by the insured's physician, advanced practice registered nurse, physician assistant, certified nurse midwife or other medical provider.
- Requirements for each screening or service may vary and may be subject to Medical Necessity review.
- Diagnostic and screenings services may include, but may not be limited to:
- Mammograms, including mammograms provided by Breast Tomosynthesis.
- Comprehensive Ultrasound screening of an entire breast or breasts [if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
- Magnetic Resonance Imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.
- Mastectomies intended to prevent disease (prophylactic mastectomy).
- Genetic Testing.
- Routine screening procedures and surveillance tests for ovarian cancer.
- 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.*)
- Prostate Specific Antigen (PSA) tests to screen for prostate cancer for men who are symptomatic or whose biological father or brother has been diagnosed with prostate cancer and for all men fifty years of age or older. The treatment of prostate cancer is covered provided such treatment is medically necessary and in accordance with guidelines established by the *National Comprehensive Cancer Network*, the *American Cancer Society* or the *American Society of Clinical Oncology*.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

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*.

19. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services including radiologists, anesthesiologists and pathologists.

20. Medical Supplies

Benefits for medical supplies for Covered Health Care Services required for the treatment of Sickness or Injury. This includes maintenance supplies, such as ostomy supplies.

Benefits for diabetic supplies are described under *Diabetes Services*. Benefits for supplies associated with DME are described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

21. Mental Health Care Services

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

Benefits include the following levels of care:

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.
- Intensive, home-based services designed to address specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.
- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities.
- Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician, or advanced practice registered nurse (APRN) and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:

- The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, or advanced practice registered nurse (APRN), psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
- Extended day treatment programs.
 - Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities.
 - Observation beds in acute hospital settings.
 - Psychological and neuropsychological testing conducted by an appropriately licensed health care provider.
 - Trauma screening conducted by a licensed behavioral health professional.
 - Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional.
 - Substance use screening conducted by a licensed behavioral health professional.

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 include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA).

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

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

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

22. Oral Surgery

The following limited dental and oral surgical procedures in either an inpatient or outpatient setting:

- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Removal of cysts related to teeth is not covered.
- Surgical and nonsurgical medical procedures for temporomandibular joint (TMJ) disorders and orthognathic surgery.

23. Orthoptic Exercises and Corneal Topographic Procedures

Orthoptic exercises for the treatment of the following conditions:

- Amblyopia for Covered Persons up to age 19. Treatment includes patching and penalization therapies.
- Convergence insufficiency.

Corneal topographic procedures for the treatment of certain conditions.

24. Ostomy Supplies

Benefits for Medically Necessary appliances and supplies relating to an ostomy include, but are not limited to, the following:

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

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

25. Pharmaceutical Products – Outpatient

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

Benefits are provided for Pharmaceutical Products which, due to their 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 may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card. Step therapy does not apply to Pain Management services and cancer treatment for a member who has been diagnosed with stage IV metastatic cancer provided a prescribed drug is in compliance with approved federal Food and Drug Administration indications.

Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Co-payment and/or Co-insurance, you may receive Pharmaceutical Products 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 order or refill and/or the amount dispensed per month's supply.

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

Certain Specialty Pharmaceutical Products are eligible for coupons or offers 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 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 Specialty Pharmaceutical Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Schedule of Benefits*.

The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.

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.

26. 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 allergy testing and treatment, including routine allergy injections.

Immunization coverage and 20 minute immunization consultation between Member and the Physician.

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

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

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

27. Pregnancy - Maternity Services

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

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

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

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If discharge occurs earlier than these timeframes, we will pay Benefits for a follow-up visit within 48 hours of discharge and an additional follow-up visit within seven days of discharge.

Follow-up services will include, but not limited to, the following:

- Physical assessment of the newborn.
- Parent education.
- Assistance and training in breast or bottle feeding, which is covered as long as Medically Necessary and is not limited to the follow-up visit within 48 hours of discharge or the additional follow-up visit within 7 days of discharge.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests.

Follow-up services must be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations. Follow-up services must be provided by a qualified health care personnel trained in post-partum maternal and newborn pediatric care.

28. 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).

29. 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*.
- 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. 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.

30. 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, Medical Equipment and Prosthetics*.

31. Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implementation, which removal is determined to be Medically Necessary by the Physician.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, 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.

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

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

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

Benefits are not available for maintenance/preventive treatment.

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

33. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

Included under this section is coverage for colorectal cancer screenings, including, but not limited to annual fecal occult blood test, colonoscopy and flexible sigmoidoscopy/radiologic imaging in accordance with the recommendations established by the *American Cancer Society*. There is no cost share when more than 1 colonoscopy is ordered in a policy year.

34. Second and Third Opinions

Second and third opinions requested by you or by us.

At your request:

- If you disagree with a Network provider's recommended course of treatment, you may request that another provider render a second opinion.
- If the first and second opinions do not agree, we will designate a Network provider to render a third opinion at no cost to you.
- After reviewing the third opinion, we will cover the Covered Health Care Services supported by a majority of the providers reviewing your case.
- If the first opinion concerns a diagnosis of cancer (either negative or positive) or treatment for cancer, you may obtain a second opinion from an out-of-Network provider on a Network basis.

At our request:

- We reserve the right to require a second opinion for any surgical procedure.
- If a second surgical opinion is required, we will refer you to a Network provider for the second opinion at no cost to you.
- In the event that the first and second surgical opinions differ, a third opinion will be required. We will designate another Network provider for a third opinion at no cost to you.
- The third opinion will determine whether the procedure will be covered. The providers who render the second or third opinion are not eligible to perform the procedure.

35. 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 including radiologists, anesthesiologists and pathologists.

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.

36. Spine and Joint Surgeries

Benefits for certain inpatient and outpatient spine and joint surgeries which are ordered by a Physician. Spine and joint surgical procedures include the following:

- Spine fusion and disc surgery.
- Total joint replacement and joint revision surgeries.
- Scopic procedures for joints.

37. Substance-Related and Addictive Disorders Services

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

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.
- Intensive, home-based services designed to address specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.

- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities. Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:
 - The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
 - Extended day treatment programs.
 - Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities.
 - Observation beds in acute hospital settings.
 - Psychological and neuropsychological testing conducted by an appropriately licensed health care provider.
 - Trauma screening conducted by a licensed behavioral health professional.
 - Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional.
 - Substance use screening conducted by a licensed behavioral health professional.

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

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

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

38. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

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

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.

- Hysteroscopy.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Sterilization. Note: Sterilization for women is not subject to cost share.
- Physician services including radiologists, anesthesiologists and pathologists.
- Please refer to our provider directory located on our website at www.myuhc.com for assistance with identifying the different types of facilities.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

39. Termination of Pregnancy

Therapeutic abortions and abortions in the case of rape, incest or fetal malformation. Elective abortions are covered. Benefits are limited as stated in the *Schedule of Benefits*.

40. Telehealth Services

Telehealth services are covered when services are received for the diagnosis, prevention, treatment, cure or relief of a physical or mental health conditions, illness, injury or disease. These services are covered to the same extent that the same services would be covered if received during a face to face consultation. The cost share for Telehealth services will be based on the type of provider who rendered the services (Primary Care Physician, Specialist, registered nurse or advanced practice registered nurse), as outlined in your Summary of Benefits. If these services are received from a network Telehealth provider, they will be covered at the network level of benefits, and if received from an Out-of-Network provider, they will be covered at the Out-of-Network level of benefits.

Physicians and APRNs to certify a qualifying patient's use of medical marijuana and provide follow -up care via telehealth.

For purposes of this Benefit, "Telehealth" means the mode of delivering health care or other health care services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a covered member's physical and mental health and includes:

- Interaction between the patient at an originating site and the Telehealth provider at a distant site, and
 - Synchronous interactions, asynchronous store and forward transfers or remote monitoring.
- Telehealth does not include the use of facsimile, texting or electronic mail.

41. Temporomandibular Joint Services

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

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

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

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

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

Non-surgical treatment including, but not limited to, appliances, behavior modification, physiotherapy and prosthodontic therapy is not covered.

42. Therapeutic Treatments - Outpatient

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

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

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 including anesthesiologists, pathologists and radiologists.
- Sleep studies.

43. Transplantation Services

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

Examples of transplants for which Benefits are available include:

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

Donor costs 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.

Human leukocyte antigen testing or histocompatibility locus antigen testing for A, B and DR antigens (testing to determine the compatibility for bone marrow transplants). The bone marrow testing must be performed at a facility certified under the federal Clinical Laboratory Improvement Act and accredited by the American Society for Histocompatibility and Immunogenetics. Enrollees must register for the National Marrow Donor Program when being tested.

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

- Transportation, Lodging and Meal Expenses for Transplants
- Expenses for transplantation, lodging, and meals for the transplant recipient and his or her companion are reimbursable per transplant episode.
- A “transplant episode” is the time from the initial evaluation for the transplant until 90 days after the recipient is discharged from the transplant facility or until the recipient is cleared to return home, whichever is sooner.
- The transplant facility must be more than 300 miles from the transplant recipient’s home for this reimbursement to apply.
- Transportation costs incurred for travel to and from the transplant facility for the transplant recipient and one other individual accompanying the recipient are covered.
- If air transportation is chosen, coverage includes round trip transportation for the transplant recipient and one other individual accompanying the recipient up to two round trips per person.
- If travel occurs via automobile, mileage will be reimbursed based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was undertaken for a maximum of one round trip from the transplant recipient’s home to the transplant facility.
- Transportation, lodging and meal receipts must be submitted to us at the appropriate address listed in the information you receive from us when authorizing this reimbursement.
- There is no coverage for the following expenses:
 - Any expenses for anyone other than the transplant recipient and the designated traveling companion.
 - Any expenses other than the transportation, lodging and meals described in this provision.
 - Local transportation costs while at the transplant facility.
 - Rental car costs.

44. 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*.

45. Virtual Care Services

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

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

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs.

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

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

46. Wigs

Wigs and other scalp hair prosthesis for a Covered Person who suffers hair loss as a result of chemotherapy when prescribed by a licensed oncologist.

Additional Benefits Required By Connecticut Law

47. Craniofacial Disorders

Benefits for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Covered Persons eighteen years of age or younger when prescribed by a craniofacial team recognized by the *American Cleft Palate Craniofacial Association*. This does not provide coverage for cosmetic surgery.

48. Dental Services *

Surgery, general anesthesia, nursing and associated Hospital or Alternative Facility services provided in conjunction with inpatient, outpatient or one-day dental services when the dentist or oral surgeon and the Physician determine that the services are Medically Necessary for the treatment of either of the following types of patient:

- A person who is determined by a dentist, in conjunction with a Physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- A person who has a developmental disability, as determined by a Physician who specializes in primary care that places the person at serious risk.

49. Developmental Needs of Children & Youth with Cancer

- Neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in children due to chemotherapy or radiation treatment.

50. Early Intervention Services

- Coverage for early intervention services provided as part of an individualized family services plan as defined by Connecticut law for a child from birth until the child's third birthday.
- Turns three years of age on or after May first and not later than the first day of the next school year commencing July first.
- Early intervention services are not subject to co-insurance, co-payments, deductibles or other out-of-pocket expenses, regardless of whether the provider is a Network or Out-of-Network provider.

51. Lyme Disease Services

Coverage for Lyme disease treatment, including but not limited to up to 30 days of intravenous antibiotic therapy and/or sixty days of oral antibiotic therapy and further treatment will be provided if recommended.

52. Medical Foods

Coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the treatment of inherited metabolic diseases and are administered under the direction of a Physician.

In addition, coverage must be provided for specialized formulas when they are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician.

Inherited metabolic diseases - a disease for which newborn screening is required under section 19a-55 of the general statutes of Connecticut and cystic fibrosis.

Amino acid modified preparation - a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Specialized formula - a nutritional formula for children up to the age of twelve years of age that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

53. Nutritional Counseling

Nutritional Counseling is a Covered Health Care Service for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity. In addition, the services must be prescribed by a licensed health care professional and provided by a certified, registered or licensed health care professional in a physician's office or outpatient facility.

54. Pain Management

Covered Health Care Services received by a pain management specialist for pain treatment which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

55. Wound Care Supplies

Wound care supplies for the treatment of epidermolysis bullosa when administered under the direction of a Physician. Epidermolysis bullosa is a rare inherited genetic disorder caused by a mutation in the keratin gene. The disorder is characterized by the presence of extremely fragile skin and recurrent blister formation, resulting from minor mechanical friction or trauma. The resulting wounds require continuous treatment.

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. This exclusion does not apply to acupressure and acupuncture services for which Benefits are available as described under *Pain Management* in *Section 1: Covered Health Care Services*.
2. Aromatherapy.
3. Hypnotism.
4. Rolfing.
5. Wilderness, adventure, camping, outdoor, or other similar programs.
6. 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). This exclusion does not apply to services for which Benefits are provided as described under in *Section 1: Covered Health Care Services*.

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

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Removal of teeth (including wisdom teeth).
- 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*.

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.
6. Removal of cysts related to teeth.

C. Devices, Appliances, Medical Equipment 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.
 8. Powered and non-powered exoskeleton devices.
 9. 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*.
 10. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
 11. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to medications covered under *Section 1: Covered Health Care Services*.
2. Self-administered or self-infused medications. This exclusion does not apply to medications covered under *Diabetes Services* in *Section 1: Covered Health Care Services*. 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.
3. Over-the-counter drugs and treatments, unless Medically Necessary.
4. Growth hormone therapy.
5. 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*. However, you have a life-threatening Sickness or condition or medically necessary reason to cover a newly approved FDA medication, the provider could request coverage of the new drug and a clinical review would be provided.
6. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year, unless medically necessary.
7. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year, unless medically necessary.
8. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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

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. Mental Health Care Services

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

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

I. 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.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - 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, escalators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers or water purifiers.
 - Jacuzzis.
 - Mattresses or waterbeds.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Safety equipment.

- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Swimming pools.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Sclerotherapy treatment of veins.
 - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 The exception to this is the removal of a breast implant which was implanted on or prior to July 1, 1994, without regard to the purpose of such implantation.
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 control. All services, supplies, programs and surgical procedures for the purpose of weight control, except surgical procedures that are Medically Necessary for the treatment of morbid obesity.
6. Wigs, except as required for hair loss due to chemotherapy as described in *Section 1: Covered Health Care Services*.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
8. Biofeedback, except as required for treatment of Urinary Incontinence.
9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; and dental restorations. Medically Necessary TMJ services for surgical medical and dental should be covered.
10. Non-surgical treatment of obesity.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
13. Intracellular micronutrient testing.
14. Cellular and Gene Therapy services not received from a Designated Provider.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal 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.
4. No-show charges. If a provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

N. Reproduction

1. The following infertility treatment-related services:

- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, testicular tissue, and ovarian tissue, unless harvesting eggs for surrogate is a covered expense if harvested from the member.
 - Donor services.
2. The following services related to a Gestational Carrier or Surrogate:
- All costs related to reproductive techniques including:
 - ◆ Assisted Reproductive Technology (ART).
 - ◆ Artificial insemination.
 - ◆ Intrauterine insemination.
 - ◆ Obtaining and transferring embryo(s).
 - ◆ Preimplantation Genetic Testing (PGT) and related services.

The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care 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. The reversal of voluntary sterilization.
5. Elective fertility preservation.
6. In vitro fertilization that is not used as an Assisted Reproductive Technology for the treatment of infertility. 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*.

O. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Except as otherwise provided under Conn. Gen. Stat. Section 38a – 527, health care services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements.

Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

P. Substance-Related and Addictive Disorders Services

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

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Q. Transplants

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

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other 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* or 2) transportation, lodging and meal expense for which Benefits are provided as described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain, unless such treatment is Medically Necessary and has been ordered by a pain management specialist.
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.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
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. 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.
5. 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.

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

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.

- Described as a Covered Health Care Service in this Certificate under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
 3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
 7. Follow-up care provided in a Hospital Emergency room.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Blood, blood plasma, blood derivatives and synthetic blood. This exclusion does not apply to services that are covered in *Section 1: Covered Health Care Services*. Apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not covered.
 10. Routine harvesting and storage of stem cells from newborn cord blood.
 11. Autopsy.
 12. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
 13. Services or supplies that have been fraudulently obtained.
 14. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

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.

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live or work within the Service Area.

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.

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

- Birth for the first 61 days even when no dependent coverage is purchased.
- Legal adoption.
- Placement for adoption.
- Marriage or Civil Union.
- 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 (61 days for newborns) of the event.

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

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 (61 days for newborns) 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. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health 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). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

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

If the Group terminates you for any reason other than a layoff or relocation or closing of a covered establishment, or if you voluntarily leave your place of employment, the Group may decide to not pay the premium for you and your Enrolled Dependents after the date of termination. If the Group makes this election, the Group must:

- Notify us within 72 hours of the termination of your employment so that we may process the request; and
- Notify you of the termination of health care coverage
- When the Group has exercised this election and has provided the required notices, your coverage will terminate three calendar days after termination of employment. It is the Group's responsibility to remit to you your portion of the credited premium.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **The Subscriber No Longer Lives or Works within the Service Area**

Your coverage ends on the date or the last day of the calendar month in which the Subscriber no longer lives or works in the Service Area. Coverage will end on the date of that move, even if the Subscriber does not notify us. The Subscriber or the Group must notify us if the Subscriber moves from the Service Area. The Group can provide you with specific information on which of these dates apply.

Dependent coverage will end on the policy anniversary date after the Dependent reaches age 26.

- **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." The Group can provide you with specific information on which of these dates apply.

- **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. The Group can provide you with specific information on which of these dates apply.

- **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. The Group can provide you with specific information on which of these dates apply.

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

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 31 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.

During the first two years the Policy is in effect, 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.

Notice of Termination

The Group must furnish each Subscriber notice of the termination of this Policy. The notice will be mailed or delivered to the Subscriber not less than fifteen days preceding the effective date of the termination. The notice is not required if the Group replaces this Policy with another group health insurance policy without interruption of coverage. If the Group fails to furnish the notice, the Group will be liable for benefits to the same extent as we would have been liable if the Policy had not been terminated.

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

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

Continuation 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 to find out if your Group is subject to the provisions of *COBRA*.

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

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

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

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

Continuation Coverage under State Law

Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage ends and if your coverage ends under the Policy as described below. This continuation applies to you if the Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Groups that are not subject to the terms of *COBRA*. You should call your Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.

- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.

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 180 days 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.

If a provider of ambulance services complies with the statutory provision for direct payment and that provider has not been paid from any other source, Allowed Amounts due to that provider will be paid directly to that provider instead of being paid to the Subscriber.

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.

If your Benefit plan includes an *Outpatient Prescription Drug Rider* and you need to file a claim, your claim should be submitted to:

Optum RX
PO Box 650629
Dallas, TX 75265-0629

Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us. You may assign your right to reimbursement under this Certificate to a dentist or oral surgeon provided (1) the dentist or oral surgeon does not charge you more than what the dentist/oral surgeon would charge an uninsured patient for the same services, and (2) the dentist or oral surgeon allows Us to review medical records, with at least 48 hours notice, during regular business hours.

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

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

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.

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.

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

How Do You Appeal a Claim Decision?

This section describes the process for appealing a (1) utilization review (UR) decision or (2) a benefit, network or administrative decision. The process you will need to use depends upon the type of issue you are trying to resolve. Please read the information in the Section carefully, as it describes what the different review procedures are and when and how to use them. If you are still not sure of the process to follow, call Customer Care at the telephone number shown on your ID card.

Copies of these procedures are available in many languages and can be forwarded to you subject to availability. We can also arrange to have an independent interpreter available, however our ability to provide this service depends on the availability of the interpreter. We may need to arrange to call you at a time when an interpreter is available. Additionally, you always have the right to designate a representative during this process.

Authorized Representatives

You have the right to use these procedures. It is your responsibility to initiate a Complaint or Appeal within the timeframes set forth in this Certificate of Coverage.

You may designate a person to act on your behalf, including your healthcare provider ("authorized representative"). For appeals of benefit determinations concerning urgent care, we are required to allow your healthcare provider, with knowledge of your condition, to act as your authorized representative without your written consent. A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without care or treatment that is the subject of the determination.

For all other circumstances, to authorize a representative to act on your behalf, you must provide us with written consent at the time your complaint or appeal is submitted. Because your medical records are privileged and confidential, and we want to ensure that you wish to appeal, you must submit an original signed written consent. Members who are 18 years of age or older, including a member's spouse or children, will need to provide their own signed written consent. If the member is a minor, a written consent must be signed by the member's parent or guardian.

Your authorized representative will only be authorized to act on your behalf and is required to comply with all of the conditions of your Certificate that would apply to you when you initiate any appeal or complaint. Your authorized representative is not entitled to obtain any benefits or rights under your Certificate.

Utilization Review (UR) Appeals

UR will occur whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. The utilization review appeals process should be used after you have received an initial adverse UR determination and you do not agree with our decision. All appeals are subject to a review by us to evaluate the medical necessity of the services. You may use this process to appeal adverse determinations relating to all UR determinations, regardless of whether the services requested by you or your authorized representative have not yet been rendered (pre-service), are currently being rendered (concurrent) or have already been rendered (post-service).

Please note: This UR appeals process should not be used for appeals relating to benefit, network or administrative issues.

UR appeals must be initiated within 180 days from receipt of an adverse determination (i.e., receipt of the determination notice). A decision may be rendered within the standard timeframes or may be expedited as described in this section.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Unless we have already issued a written determination, we will use our best efforts to provide written acknowledgement of the receipt of your appeal within 5 business days, but in no event later than 15 calendar days. Our decision to either uphold or reverse the adverse determination will be made and communicated to you as follows:

- Request for service (pre-service): Within 30 calendar days of our receipt of the appeal.
- Concurrent services for a member in an ongoing course of treatment (concurrent): Within 30 calendar days of our receipt of the appeal. In this instance, treatment will be continued without liability while your appeal is being reviewed.
- Coverage for services rendered (post-service): Within 60 calendar days of our receipt of the appeal.
- If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.
- This will be our final adverse determination. If you are not satisfied with our decision, you have the option of filing an External Appeal (explained in the section below, "External Appeals.")

Expedited/Urgent Utilization Review (UR) Appeals

You can expedite your UR appeal when:

- You receive an adverse determination involving continued or extended health care services, procedures or treatments or additional services while you are undergoing a course of continued treatment (concurrent) prescribed by a health care provider; or
- The timeframes of the non-expedited UR appeal process would seriously jeopardize your life, health or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the health condition, the timeframes of the non-expedited UR appeal process would cause you severe pain that cannot be managed without the care of treatment that was requested; or
- Your physician believes an immediate appeal is necessary because the timeframes of the non-expedited UR appeal process would significantly increase the risk to your health; or

- For a Substance - Related and Addictive Disorders Substance - Related and Addictive Disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.
- You have two available options for expedited reviews. **These options are not available for health care services that have already been rendered (post-service).**

1. Internal Expedited UR Appeal: This process includes procedures to facilitate a timely resolution of the appeal including, but not limited to, the sharing of information between your provider and us by telephone or facsimile. We will provide reasonable access to our clinical peer reviewer within one business day of receiving notice of an expedited UR appeal.

A decision will be rendered and communicated for an internal expedited UR appeal within the following timeframes:

- 24 hours from our receipt of the appeal when the service being appealed is for Substance - Related and Addictive Disorders Substance - Related and Addictive Disorder or co-occurring mental disorder; and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder.
- 48 hours or seventy-two hours after we receive the request if any portion of the forty-eight-hour period falls on a weekend from our receipt of the appeal for all other types of services.
- If you are not satisfied with the outcome of the expedited UR appeal, you may further appeal through the external appeal process. If we do not make a determination within 24/48 hours or seventy-two hours after we receive the request if any portion of the forty-eight-hour period falls on a weekend from our receipt of the appeal, the adverse determination will be reversed. The notice of an appeal determination will include the reasons for the determination. If the adverse determination is upheld on appeal, the notice will include the specific reason(s) and clinical rationale used to render the determination, a reference to the specific health benefit plan provisions on which the decision is based, a statement that you may receive from us, upon request and free of charge, reasonable access to and copies of all relevant documents. We will also include a notice of your right to initiate an External Appeal. A description of each process and associated timeframes will be included.
- If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.

2. External Expedited Appeal: You also have the option to seek review by an independent review organization in emergency or life-threatening circumstances. You may make a request to the Commissioner of Insurance for an expedited external appeal without first completing the internal appeals process if:

- The timeframe for completion of an expedited internal appeal may cause or exacerbate an emergency or life-threatening situation; or
- For a Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting; and
- You, or your provider acting on your behalf with your consent, have filed a request for expedited internal review.

If you choose this option, you must submit the appeal by contacting the Connecticut Insurance Department at P.O. Box 816, Hartford, CT 06142-0816 (telephone number: 860-297-3910). For more information on how to file an expedited external appeal, refer to External UR Appeals below.

Office of the Healthcare Advocate and the Division of Consumer Affairs

If we deny a requested service on the basis that the service is not Medically Necessary or because it is a contractual exclusion and you believe you have been given erroneous information, you have the right to contact either Connecticut's Office of the Healthcare Advocate or Division of Consumer Affairs for assistance. You may contact them at the address listed below:

State of Connecticut

Office of the Healthcare Advocate

P.O. Box 1543

Hartford, CT 06114

Telephone: 1-866-466-4446

E-mail: Healthcare.advocate@ct.gov

Consumer Affairs Division

P.O. Box 816

Hartford, CT 06142-0816

Telephone: 1-800-203-3447

E-mail: cid.ca@ct.gov

External UR Appeals

Under certain circumstances, you or, with your consent, your authorized representative or provider acting on your behalf, have a right to file an external appeal or expedited external appeal for the denial of coverage for services based on lack of Medically Necessary criteria or because the service is experimental or investigational for a particular medical condition. Benefit or administrative determinations are not eligible for external appeal; only utilization review issues are eligible for external appeal.

You or your authorized representative have the right to request an external UR appeal in the following situations:

- The service, procedure or treatment must otherwise be a covered service under this Certificate; and
- You must have received a final adverse determination through the UR appeals review, with a denial based on lack of medical necessity criteria or experimental/investigational treatment UNLESS it is determined that the timeframe for completion of an internal appeal may cause or exacerbate an emergency or life threatening situation. In an emergency or life-threatening situation, you or your authorized provider acting on your behalf with your consent would not need to complete the internal UR appeal in order to file for an external appeal.

How to File an External Appeal

To file an expedited external appeal, you can submit an application with the Connecticut Insurance Department immediately following receipt of our initial adverse determination or appeal determination.

If the expedited external appeal is not accepted on an expedited basis, and you have not previously completed the internal UR appeal process, you may resume the internal appeal process until all internal appeals are exhausted. You may then file for a standard external appeal within 120 days following receipt of the final denial letter.

If the internal appeals were previously exhausted, your rejected expedited appeal will automatically be eligible for consideration for standard external appeal. You are not required to submit a new application.

Remember: You may not file an expedited external review for services which have already been provided (post-service).

To file a non-expedited external appeal, you have 120 days to initiate the appeal through the State of Connecticut Insurance Department after you have completed the internal UR appeal or after We and you both agree to waive the internal appeal process

Requests for external appeals and expedited external appeals must be in writing on an external appeal application form. The application form will include instructions on how to complete and submit the form to the Commissioner. You or your authorized representative (and Provider, if applicable) must release all pertinent medical information concerning your medical condition and request for services. You may contact Connecticut's Insurance Department at the following address or telephone number:

Connecticut Insurance Department

PO Box 816

Hartford, CT 06142-0816

Attn: Utilization Review Nurse Coordinator

(860) 297-3910

For Overnight delivery only, please send Your application for External Review to:

State of Connecticut Insurance Department

153 Market Street

P.O. Box 816

Hartford, CT 06142-0816

860-297-3910

The following items must be included in your Appeal. Your Appeal will be rejected if all of these items are not included:

- A completed "request for External Appeal" form.
- An authorization form allowing us and your health care professional to release your medical information to the independent review organization.
- Evidence of being an enrollee of the plan (photocopy of your insurance card).
- Copies of all correspondence from us.
- A copy of the final determination letter indicating that all internal appeal mechanisms have been exhausted.
- A copy of your policy or certificate of coverage.

In addition to the required items outlined above, you may also submit any additional information relevant to your condition.

Following receipt of the request for external appeal or expedited external appeal, the Insurance Commissioner will forward the appeal to us so that we may confirm that your appeal is complete and satisfies the conditions listed below. We will complete this review within 5 business days for an external review request or within 1 day for an expedited external review request.

1. You are or were a member of the plan at the time of the event that is subject of the adverse determination.
2. The service in question reasonably appears to be a covered service under the Certificate but was denied because it does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

3. The service in question reasonably appears to be a covered Service under the Certificate but was denied because it is experimental or investigational for a particular medical condition, is not explicitly listed as an excluded benefit under your health benefit plan and your treating health care professional has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving your medical condition;
 - Standard health care services are not medically appropriate for you.
 - There is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment.

In addition, your treating health care professional:

- Has recommended a health care service or treatment that he/she certifies, in writing, is likely to be more beneficial to you, in his/her opinion, than any available standard health care services or treatments; or
 - Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat your condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the denied health care service or treatment is likely to be more beneficial to you than any available standard health care services or treatments.
4. You have completed at least the First Level Appeal process;
 5. You have provided all of the required information

Once we have completed our review, we will notify you, your authorized representative (if appropriate) and the Insurance Commissioner whether the appeal is complete and eligible for external review. We will communicate our findings in writing within 1 business day for an external appeal or on the day the review is completed for an expedited external appeal. If your appeal is not complete, the notice will include what information or materials are missing. If your appeal is not eligible, the notice will include the reason(s) it is not eligible. In either instance, you may appeal this determination to the Insurance Commissioner.

If your appeal is eligible for external review, the Commissioner will assign your appeal to an Independent Review Organization. We will send a notice to the Commissioner, you, and your authorized representative (if appropriate) informing you that 1) your external review or expedited external review has been accepted, and 2) that you have 5 business days from receipt of the notice to submit any additional information and where the additional information should be submitted. If additional information is submitted later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information.

We will forward the medical and treatment plan records we relied upon in making our determination to the Independent Review Organization. If the documentation represents a material change from the documentation upon which we based our adverse determination or denial, we will have the opportunity to consider the documentation and amend or confirm our adverse determination or denial. This review will not delay or terminate the external review.

The Independent Review Organization will make a determination with regard to the appeal within the following timeframes:

- External Reviews: within 45 days after assignment from the Commissioner
- External Review involving an experimental or investigational treatment: within 20 days after assignment from the Commissioner
- Expedited External Reviews: as expeditiously as your condition requires, but not later than:
 - 24 hours after assignment from the Commissioner when the service being appealed is for Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or

co-occurring mental disorder; and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder.

- 48 hours or seventy-two hours after we receive the request if any portion of the forty-eight hour period falls on a weekend from our receipt of the appeal after assignment from the Commissioner for all other types of services.
- Expedited External Reviews involving an experimental or investigational treatment: as expeditiously as your conditions requires, but not later than 5 days after assignment from the Commissioner

Upon completion of the review, the Independent Review Organization will communicate its decision in writing to you, your authorized representative (if appropriate), the Commissioner and to us. If the decision is to reverse or revise our initial or final adverse determination, we will immediately approve the coverage, subject to the terms and conditions of this Certificate. The decision will be binding.

Benefit/Administrative Appeals

The benefit/administrative appeals process is used after you have received an initial adverse determination concerning a claim for benefits or an administrative issue. Benefit issues include, but are not limited to: denials based on benefit exclusions or limitations and claims payment disputes. Administrative issues would include issues such as access to providers, eligibility or enrollment issues.

Please Note: Benefit and administrative issues do not include determinations concerning the medical necessity of covered services. If we have denied your claims or request for services because we believe the services are not Medically Necessary, do not use the process outlined in this section. Please refer to the above section, Utilization Review (UR) Appeals.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Within 3 business days of receipt of your appeal, we will send you a notice informing you of your right to submit to us any additional written material you would like us to consider as part of our review. The notice will also provide the address, telephone number and the name of the Department handling your appeal.

Benefit/administrative appeals must be initiated by you or your authorized representative within 180 days from receipt of an adverse determination (i.e., an Explanation of Benefits, Denial Notice) or, for other issues, from the date when you became aware of the issue that initiated the appeal.

We will provide you or your authorized representative or your provider with our written decision (by mail or electronic means) and the detailed reasons for our decision including clinical rationale (if applicable) and references to any specific plan provisions on which our decision was based within 20 business days of receipt of your appeal.

This will be our final position.

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 can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- 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.

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 and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, (other than long-term care contracts under the LTC Partnership Program in Connecticut), 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; other than long-term care contracts under the LTC Partnership Program in Connecticut), 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 the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the Plans involved. 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.

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.

End Stage Renal Disease

When a member has end stage renal disease (ESRD) and she/he has enrolled for Medicare coverage, Benefits are coordinated in accordance with the Medicare Secondary Payer Rules.

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.
- Notifying you of when the Policy ends.

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.

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

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

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

Notice

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

Statements by Group or Subscriber

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-Oxford 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. We will pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

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

This section is subject to the decisions rendered in Section 6: Questions, Complaints and Appeals, as you always have the right to file a complaint or appeal.

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.

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

Amendments to the Policy

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

Subject to applicable law, we have the right to subrogation and reimbursement. 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 fully return to us 100% of any Benefits you receive for that Sickness or Injury. 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. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying 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.
 - Providing any relevant information requested by us.

- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any 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.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the

Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- 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.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful 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. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- 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.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- 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, 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 this happens, we will explain the problem to you, and you must return the overpayment to us. If the refund is due from you do not return the overpayment to us within 60 days after receiving notification from us, 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. However, we will not initiate overpayment recovery efforts more than 24 months after the original payment was made unless we have a reasonable belief of fraud or intentional misrepresentation.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

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

Section 9: Defined Terms

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

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

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

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

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

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

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

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

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

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

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

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

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).

- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Applied Behavior Analysis - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

Autism Spectrum Disorder - means "autism spectrum disorder" as set forth in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

Behavior Therapy - any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Connecticut Commissioner of Social Services, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with Autism Spectrum Disorder, that are:

- Provided to children less than twenty-one years of age; and
- Provided or supervised by any of the following:
 - a behavior analyst who is certified by the *Behavior Analyst Certification Board*,
 - a licensed Physician, or
 - a licensed psychologist.
 - Behavioral Therapy is considered to be supervised by a behavior analyst, licensed Physician or licensed psychologist when the supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provided for each ten hours of behavioral therapy provided by the supervised provider.
 - Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorders.

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

Clinical Peer - will be used to evaluate the clinical appropriateness of an adverse determination and for external review determinations. A clinical peer is a physician or other health care professional who:

- (A) holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
- (B) for an urgent care review concerning
 - A child or adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or a child or adolescent mental disorder, holds (1) a national board certification in child and adolescent psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or child and adolescent mental disorder, as applicable, or
 - An adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or an adult mental disorder, holds (1) a national board certification in psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or adult mental disorders, as applicable.

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.

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.

Continuity of Care - If you are undergoing an active course of treatment when a provider leaves the network, you may be eligible for Continuity of Care. For purposes of Continuity of Care, the following definitions apply:

Active Course of Treatment:

- A Medically Necessary, ongoing course of treatment for a life-threatening condition; or
- A Medically Necessary, ongoing course of treatment for a serious condition; or
- Medically Necessary care provided during the second or third trimester of pregnancy; or
- A Medically Necessary, ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the covered person's condition or interfere with anticipated outcomes.
- **Life-Threatening Condition:** a disease or condition for which the likelihood of death is probable unless the course of such disease or condition is interrupted.
- **Serious Condition:** a disease or condition that requires complex ongoing care such as chemotherapy, radiation therapy or postoperative visits, which the Covered Person is currently receiving.
- **Treating Network Provider:** a Member's treating health care provider or a facility at which the Member is receiving treatment that is removed from or leaves a health carrier's network.
- If you receive notice from us that your Treating Network Provider is no longer in our Network, you may be able to continue to receive Covered Health Care Services from your former Network Provider on an in-network basis in the following instances:
- You are in your second or third trimester of pregnancy: You may receive Covered Health Care Services through delivery and any post-partum care directly related to the delivery.
- You are undergoing an active course of treatment: We may extend in-network coverage to the earliest of the following:
 - ◆ Termination of the course of treatment by you or your treating provider; or
 - ◆ 90 days after the treating provider is removed from or leaves the network, unless Our Medical Director determines that a longer period is necessary; or
 - ◆ The date that care is successfully transitioned to another network provider; or
 - ◆ The date the benefit limitations under the health benefit plan are met or exceeded; or
 - ◆ The date We determine care is no longer Medically Necessary.
 - ◆ Continuity of Care is available only if the provider agrees to continue to follow Our reimbursement rates, policies and procedures. If the provider so agrees, you will receive these Covered Health Care Services as if they are being provided by a network provider. You will only be responsible for the in-network cost share, which will be applied to the in-network deductible and Out-of-Pocket Limit, if applicable to your plan. Pregnancies that are affected by this provision are automatically covered on an in-network basis.

If the Treating Network Provider was terminated by Us due to quality of care, Continuity of Care is not available.

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

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

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

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

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

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

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

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

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

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

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

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

The Dependent age limit will be specified in your *Schedule of Benefits*, including if your Group has chosen a Dependent age above 26.

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

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

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

Designated Provider - a provider and/or facility that:

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

A Designated Provider may or may not be located within the Service Area. Not all Network Hospitals or Network Physicians are Designated Providers.

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

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

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

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

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

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

- Placing the 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.

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, except that coverage is provided for a drug which has been prescribed for treatment of certain types of cancer for which the drug has not been approved by the *FDA*, provided the drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following three established reference compendia: (1) *The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital's Pharmacist's American Hospital Formulary Service Drug Information (AHES-DI)*. However, there is no coverage for any drug which the *FDA* has determined to be contraindicated for the specific cancer for which the drug has been prescribed.

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

except that Benefits for a procedure, treatment or the use of any drug will not be denied as experimental if such procedure, treatment or drug, for the illness of condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase 3 clinical trial.

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.

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

Genetic Testing - 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 - an agency or organization which meets all of the following:

- Is primarily engaged in and is federally certified as a home health agency and is duly licensed (if such licensing is required) by the appropriate licensing authority to provide nursing and other therapeutic services.
- Has their policy established by a professional group associated with the agency or organization, including at least one Physician and at least one registered nurse, to govern the services provided.
- Provides for full-time supervision of such services by a Physician or by an advanced practiced registered nurse.
- Maintains a complete medical record on each patient.
- Has an administrator.

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.

Individual Treatment Plan - a treatment plan prescribed by a Physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

Medically Necessary - health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.

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, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), 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.

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, or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

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. In determining whether health care services are Medically Necessary, we reserve the right to consult a subject matter expert of our choice and apply physician relevant specialty society recommendations.

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.

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 *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic*

and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Care Service. Mental or nervous conditions" does not include additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service. Mental or nervous conditions" does not include additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

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.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* Criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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

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

Out-of-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 - 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, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

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

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

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

- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

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

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

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

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

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

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

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a 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 if you have Benefits for Outpatient Prescription Drugs, while presented in Rider format, they 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.

Service Area - the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

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

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

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

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

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

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

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *Diagnostic and Statistical Manual of 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/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Surprise Bill - A bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider or out-of-network clinical laboratories, where such services were rendered by such out-of-network provider or out-of-network clinical laboratories, at an

in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider.

A "surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network or out-of-network clinical laboratories.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

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

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

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

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

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

Please note:

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

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Outpatient Prescription Drug Rider

Oxford Health Plans (CT), Inc.

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 Oxford Health Plans (CT), Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *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*.



Stephen J. Farrell

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.

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 or Co-insurance and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You

may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, by contacting us at www.myuhc.com or the telephone number on your ID card.

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. We will 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.

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc.com or the telephone number on your ID card.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you must meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your *Certificate*, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

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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 Drugs section of the Schedule of Benefits for applicable Co-payments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service including any medically necessary FDA approved Drug to treat a covered injury or sickness or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drugs* section of the *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. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
4. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to drugs for the treatment of a disabling or life-threatening chronic disease or cancer that have not been approved by the *Federal Food and Drug Administration* for that indication, if the drug has been prescribed for a Covered Person who has been diagnosed with a disabling or life-threatening chronic disease or cancer, provided the drug is recognized for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed in one of the following established reference compendia: (1) *The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI)*. This exception does not provide coverage for any experimental or investigational drugs or any drug which the *Federal Food and Drug Administration* has determined to be contraindicated for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws, subject to applicable law.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
11. Certain unit dose packaging or repackagers of Prescription Drug Products.

12. Medications used for cosmetic purposes, except for medications prescribed for gender identity reasons as outlined in your *Certificate of Coverage*. These medications require medical necessity review by Us.
13. 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, except that such review and approval of new Prescription Drug Products and/or new dosage forms will not be required for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in a substantially accepted peer-reviewed medical literature.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Prescription Drug Products when prescribed to treat infertility except that infertility coverage is available for Covered Persons with the following limitations: Prescription Drug Products associated with IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful.
16. Certain Prescription Drug Products for tobacco cessation.
17. 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 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 either Tier 2 or Tier 3.)
18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
19. Growth hormone therapy. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
20. Any product for which the primary use is a source of nutrition, nutritional supplements, ordinary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury except for the following products when administered under the direction of a Physician: 1) amino acid modified preparations and low protein medical food products for the treatment of inherited metabolic diseases, as defined by state law; and 2) Specialized Formulas when such Specialized Formulas are Medically Necessary for the treatment of a disease or condition.
21. A Prescription Drug Product that contains marijuana, including medical marijuana unless prescribed as a treatment for pain management.
22. A Prescription Drug Product with either:
 - An approved biosimilar.
 - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product.
- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

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

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

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.

Infertility - not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

- One year, if you are a female under age 35.
- Six months, if you are a female age 35 or older.

In addition, in order to be eligible for Benefits, you must also:

- Have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

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

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Out-of-Pocket Drug Limit - the maximum amount you pay for covered Prescription Drug Products every year. The *Outpatient Prescription Drugs* section of the *Schedule of Benefits* will tell you how the Out-of-Pocket Drug Limit applies.

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*.
- 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.

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. The amount you pay for a prescription will be the lesser amount of the drug, you will not have to pay the applicable copayment if the drug cost is less.

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.
- Hypodermic needles or syringes
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:

- standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
 - glucose meters, including continuous glucose monitors.
 - any medically necessary diabetic supplies.
- Topical dental preparations.

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.

Specialized Formula - A nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products include 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 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.

UnitedHealthcare Rewards Rider

Oxford Health Plans (CT), Inc.

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 Oxford Health Plans (CT), Inc. 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 wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

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

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health 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. |
| Active - Fitness | 30 minutes or more of activity as designated by the program or 10,000 or more steps per day | |
| Other Health-Related Actions and/or Activities | One or more actions and/or activities defined by us and aimed at the following: <ul style="list-style-type: none"> • Health education; • Improving health; or | |

| | | |
|--|----------------------|--|
| | • Maintaining health | |
|--|----------------------|--|

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

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

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

Rewards

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

Device

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



Stephen J. Farrell

President

Sweat Equity Fitness Reimbursement Rider

Oxford Health Plans (CT), Inc.

This Rider to the Policy is issued to the Group and provides a description of the Sweat Equity Fitness Reimbursement 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 (Certificate)* in *Section 9: Defined Terms*.

When we use the words "we", "us", and "our" in this document, we are referring to Oxford Health Plans (CT), Inc.. When we use the words "you" and "your" we are referring to the Subscriber and Spouse and Enrolled Dependents.

Sweat Equity Fitness Reimbursement Program

The purpose of this fitness reimbursement program is to encourage you to take a more active role in managing your health and well-being.

We will provide partial reimbursement for eligible fees associated with certain exercise that promotes cardiovascular wellness as described below.

Exercise activity fees include costs you pay for exercise facility fees, or exercise facility and class membership fees, outdoor bike rentals, organized group exercise classes, individual fitness instruction, organized group physical event, such as a marathon but only if such fees are paid to facilities or organizations which maintain equipment and/or offer programs, which may include certain digital application-based exercise programs, that promote cardiovascular wellness and are available to the general public. You can call us at the telephone number on your ID card for the current list of any eligible digital application-based exercise programs.

Membership in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits, organized group exercise classes, sessions, bike rides or organized group physical events. We will not provide reimbursement for the purchase of equipment, clothing, vitamins or other items or services that may be offered by the facility or organization (e.g., massages, etc.).

In order to be eligible for reimbursement, you must:

- Be an active member of the facility or program, attend organized group classes at the exercise facility or organization, and
- Complete a combined total of 50 visits, organized group classes, sessions, bike rides or organized group physical events in a six-month period.

In order to obtain reimbursement, at the end of the six-month period, you must submit:

- A completed reimbursement form from the facility or program of your visits, sessions, and events. Each time you use the exercise facility, a facility representative must sign and date the reimbursement form; documentation of the visits, such a system-generated, dated accounting of your workout(s).
- A copy of your current facility bill(s), class or program bill which shows the fee paid for your class membership, workout visits, organized group classes, sessions, bike rides or organized group physical events.
- A copy of the brochure or website printout that outlines the services or programs the exercise facility, class, session or event offers.

Once we receive the completed reimbursement form; documentation of the visits and the facility, class, event, or program bill(s), the Subscriber will be reimbursed up to \$200 and each Enrolled Dependent will be reimbursed up to \$100 or the actual cost of the eligible facility, class, program, session, event or membership per six month period, whichever is less. If you are unable to meet a standard related to a health factor for reimbursement under this fitness reimbursement program, you might qualify for an opportunity to earn the same reward by different means. Call us at the number on your identification (ID card, and we will work with you and, if necessary, your Physician, to find another way for you to earn the same reward.

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

Reimbursement must be requested within 120 days of the end of the six-month period. Reimbursement will be issued only after you have completed each six-month period even if 50 visits are completed sooner.



Stephen J. Farrell

President

Real Appeal Rider

Oxford Health Plans (CT), Inc.

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 13 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.



Stephen J. Farrell

President

Dependent Age Limit

The Dependent age limit is 26. Coverage ends upon the Policy's anniversary date.

Domestic Partner Rider

Oxford Health Plans (CT), Inc.

This Rider to the Policy is issued to the Group and provides coverage for Domestic Partners.

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 the Certificate of Coverage (*Certificate*) in *Section 9: Defined Terms* and in this Rider below.

When we use the words "we", "us", and "our" in this document, we are referring Oxford Health Plans (CT), Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Coverage for Domestic Partners

The provisions below replace the provision shown in the *Certificate* in order to add coverage for Domestic Partners when they are enrolled as Dependents of Subscribers.

Section 3: When Coverage Begins

The section titled Adding New Dependents in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 (61 days for newborns) of the event.

The section titled Special Enrollment Period in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 (61 days for newborns) days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day 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 9: Defined Terms

The definition of Dependent in the Certificate under Section 9: Defined Terms is replaced with the following:

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*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

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

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the policy anniversary date following the date the child reaches age 26.

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

The following definitions of Domestic Partner and Domestic Partnership are added to the Certificate under Section 9: Defined Terms:

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 and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - They have a single dedicated relationship of at least 6 - 18 months.
 - They have joint ownership of a residence.
 - They have at least two of the following:

- ◆ A joint ownership of an automobile.
- ◆ A joint checking, bank or investment account.
- ◆ A joint credit account.
- ◆ A lease for a residence identifying both partners as tenants.
- ◆ A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.



Stephen J. Farrell
President

Zero Cost Share Medications Addendum

Oxford Health Plans (CT), Inc.

As described in this addendum, certain Prescription Drug Products as described in the *Outpatient Prescription Drug Rider* and *Schedule of Benefits* are modified as stated below.

Because this addendum 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 (Certificate)* in *Section 9: Defined Terms*, in the *Outpatient Prescription Drug Rider* in *Section 3: Defined Terms*, and in this addendum below.

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Plans (CT), Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

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

The following definition is added to *Section 3: Defined Terms* in the *Outpatient Prescription Drug Rider*:

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). 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.

The List of Zero Cost Share Medications includes certain Prescription Drug Products under these drug classes or categories:

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



Stephen J. Farrell
President

Federal Notices



Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or 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. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

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をご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ **ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយគេគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yániit'igo, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohji' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ:·Αν·μιλάτε·**Ελληνικά·(Greek)**,·υπάρχει·δωρεάν·βοήθεια·στη·γλώσσα·σας·
Παρακαλείστε·να·καλέσετε·1-866-633-2446.

ध्यान·आपो:·જો·તમે·**ગુજરાતી·(Gujarati)**·બોલતા·હો·તો·આપને·ભાષાકીય·મદદરૂપ·સેવા·
વિના·મૂલ્યે·પ્રાપ્ય·છે·

કૃપા·કરી·1-866-633-2446·પર·કોલ·કરો·

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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 60 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 1-866-633-2446 or 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. ET

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

¹For purposes of the Language Assistance Services and 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 you 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 NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2023:

We² are required by law to protect the privacy of your health information. We are also required to send 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.

The terms "information" or "health information" in this notice include any 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, such as www.myuhc.com. 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 make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may collect, use, and disclose health information needed 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. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **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 Sponsors.** 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. In addition, we 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.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or 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.** We may communicate, electronically or via telephone, these 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:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps 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 interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. 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.
- **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.** We may disclose your health information 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.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information 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 and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 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 Health

11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated 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 promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the 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. To find out where to mail your written authorization and how to revoke an 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** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures 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. **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 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 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 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 will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. 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 or have your information sent to a third party. 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. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive 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; and (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, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. 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 exercising 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.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
 PO Box 740815
 Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint 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.

²This Medical Information 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; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; 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.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; 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, 2023

We³ 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.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices 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 ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, 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, 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*.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- o **Online:** UHC_Civil_Rights@uhc.com
- o **Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- o **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

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

- o **Phone:** Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
- o **Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue. SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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をご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្វែងរកជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

o **Online:** UHC_Civil_Rights@uhc.com

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

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

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

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

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

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat identifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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ACCESS REQUEST FORM

Purpose: This Form is intended for use by an individual to exercise his/her right to access his/her protected health information in Oxford's designated record sets or the designated record sets of Oxford's Business Associates.

Individual Seeking Access

Name: _____

Address: _____

I.D. Number: _____

Telephone: _____

Scope of Access

You have the right to inspect and obtain a copy of your protected health information maintained by Oxford and its business associates. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have or any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding.

Please specify the records you wish to inspect or obtain copies of:

We may charge you to make copies and mail your protected health information. Oxford will notify you in advance of these charges. If you want to pick the copies up at our Shelton, CT office please check here _____

Signature: _____

Date: _____

Personal Representative

If this request is being made by a personal representative on behalf of the individual, please provide a description and any available documentation of authority to act as the individual's personal representative and sign below.

Print name _____

Signature _____

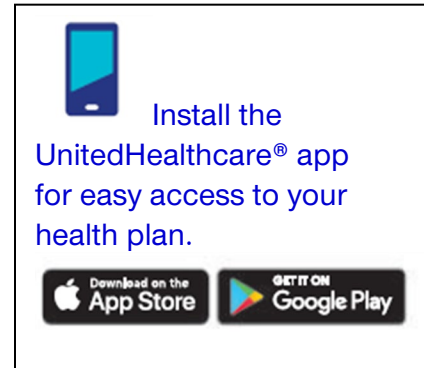
Please send completed form to:
UnitedHealthcare
HIPAA Member Rights Unit
P.O. Box 29130
Hot Springs, AR 71903

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.



Dear Oxford member,

Welcome, and thank you for selecting an Oxford plan. Your satisfaction is important to us; we want your health care benefits experience to be a positive one. As an Oxford member you have access to a host of resources, programs and tools—all meant to help you use your benefits, take charge of your health and get the most out of your plan. Following are highlights of several key plan features:



Network access

We have a large network of providers located throughout the Oxford tri-state service area.¹ Using network doctors, mental health professionals, hospitals, clinics, and laboratories typically saves you money. Most Oxford plans also include out-of-area coverage through UnitedHealthcare national networks if you live or travel outside the Oxford service area.² Use the provider search tool on the member website, **myuhc.com**[®], or through the UnitedHealthcare[®] app to look up network providers for your plan. You can also call us for assistance at the phone number on your health plan ID card.

Your personal member website and app

A self-service health plan member website, **myuhc.com**, allows you convenient, around-the-clock access to information about your health benefits, the ability to request a health plan ID card, locate a participating provider, update your personal information, and more. Register on the website and download the UnitedHealthcare app for help staying connected to your benefits.

UnitedHealthcare Rewards³

You can earn up to \$300 in a plan year for a variety of healthy actions — including things you may already be doing, like tracking your steps or getting a biometric screening. Your total earnings potential may vary based on your health plan. Find out more by signing in to the UnitedHealthcare app, select the Me tab and then Rewards. Or sign in to **myuhc.com > Rewards**.

Sweat Equity[®] Program

This wellness program offers you reimbursement toward your cardio-based physical fitness expenses—up to \$200 two times per plan year—after meeting the program requirements.⁴

Cancer support

Led by experienced cancer nurses with assistance from a board-certified medical oncologist, a hematologist, and other doctors, as well as social workers, this program offers compassionate guidance and answers for you or a family member who's faced with cancer. Call **1-866-936-6002** for support.⁵

Behavioral health solutions

For life's challenges, support is here. You have access to a 24/7 substance use help line, as well as a website dedicated to mental health and substance use resources. Call the helpline at **1-855-780-5955** 24 hours a day, 7 days a week.

continued...

Centers of Excellence

These providers are identified for meeting our quality assessment criteria and being in good standing with us and national accreditations. They have demonstrated their ability to deliver cost-effective care for complex medical conditions and other services and procedures.⁶

More information

If you have questions about this information or your coverage, or if you want to learn more about available programs and resources, sign in to **myuhc.com** or call us at the toll-free number on your health plan ID card.

Wishing you the best of health,

The Oxford Team

¹ The Oxford tri-state area includes Connecticut, New Jersey, and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau, and Suffolk). Network access may vary by plan.

² National network access may vary by plan and may not be available for all groups, including groups with an Oxford Metro Network[®] plan. Network participation subject to change.

³ UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico nor available to level funded members in District of Columbia, Hawaii, Vermont and Puerto Rico.

⁴ Reimbursement is generally limited to the lesser of \$200 (subscriber)/\$100 (covered spouse/partner) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. Refer to your benefits documents or check with your benefits administrator to find out how much you may be reimbursed. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

⁵ The Cancer Support program **should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.** The information provided through this service is for informational purposes only and provided as part of your health plan. The nurse cannot diagnose problems or recommend treatment and is not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. This nurse support service is not an insurance program and may be discontinued at any time.

⁶ The Centers of Excellence (COE) program providers and medical centers are independent contractors who render care and treatment to health plan members. The COE program does not provide direct health care services or practice medicine, and the COE providers and medical centers are solely responsible for medical judgments and related treatments. The COE program is not liable for any act or omission, including negligence, committed by any independent contracted health care professional or medical center.

The UnitedHealthcare[®] app is available for download for iPhone[®] or Android[®]. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

UnitedHealthcare and Oxford do not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card 8 a.m. – 6 p.m. ET, Monday – Friday. TTY users can dial 711.

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Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc.

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CT/NJ/NY Oxford Welcome Letter 01/24

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Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to myuhc.com, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to myuhc.com or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.



Oxford Health Insurance, Inc.

Large Business Market

KACTOHI516R1VDR123

Schedule of Benefits

Non-Tiered Network Plan

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|--|--|
| Plan Deductible Individual Family | \$2,500 per Covered Person. \$2,500 per Covered Person, not to exceed \$5,000 for all Covered Persons in a family. | \$5,000 per Covered Person. \$5,000 per Covered Person, not to exceed \$10,000 for all Covered Persons in a family. |
| Separate Prescription Drug Deductible Individual | N/A | N/A |
| Out-of-Pocket Maximum Individual Family (Includes deductibles, copays and coinsurance) | \$5,000 per Covered Person. \$5,000 per Covered Person, not to exceed \$10,000 for all Covered Persons in a family. | \$10,000 per Covered Person. \$10,000 per Covered Person, not to exceed \$20,000 for all Covered Persons in a family. |
| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Provider Office Visits | | |
| Adult/Pediatric Preventive Visits (including Preventive Mammography and Tomosynthesis) | No Cost | 20% after OON deductible is met |
| Primary Care Provider Office Visit (includes services for illness, injury, follow-up care and consultations) | \$30 per visit | 20% after OON deductible is met |
| Specialists Office Visits | \$50 per visit | 20% after OON deductible is met |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| Mental Health and Substance Abuse Office Visits | \$50 per visit | 20% after OON deductible is met |
| Outpatient Diagnostic Services | | |
| Advanced Radiology (CT/PET Scan, MRI) | Freestanding Facility: \$75 per visit up to a combined annual maximum of \$375 for MRI and CT scans; \$400 for PET scans. Hospital Based: \$75 per visit up to a combined annual maximum of \$375 for MRI and CT scans; \$400 for PET scans. | 20% after OON deductible is met |
| Laboratory Services Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year. For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider. | Designated Network \$10 per service Network 50% per service after INET deductible is met | 20% after OON deductible is met |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$40 per service | 20% after OON deductible is met |
| Mammography Ultrasound Please refer to the Certificate for further information on this benefit coverage. | No Cost | 20% after OON deductible is met |
| Prescription Drugs – Retail Pharmacy (31 day supply per prescription) | | |
| Tier 1 | \$5 copayment per prescription | 20% after OON deductible is met |
| Tier 2 | \$50 copayment per prescription | 20% after OON deductible is met |
| Tier 3 | 30% coinsurance up to \$500 maximum per prescription | 20% after OON deductible is met |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| Tier 4 | 50% coinsurance up to \$750 maximum per prescription | 20% after OON deductible is met |
| Prescription Drugs – Mail Order Pharmacy (90 day supply per prescription) | | |
| Tier 1 | \$10 copayment per prescription | 20% after OON deductible is met |
| Tier 2 | \$100 copayment per prescription | 20% after OON deductible is met |
| Tier 3 | 30% coinsurance up to \$1,000 maximum per prescription | 20% after OON deductible is met |
| Tier 4 | 50% coinsurance up to \$1,500 maximum per prescription per prescription | 20% after OON deductible is met |
| Outpatient Rehabilitative and Habilitative Services | | |
| Speech Therapy 60 visits per year limit combined for Rehabilitative (physical, speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, physical and occupational therapies). | \$30 per visit | 20% after OON deductible is met |
| Physical and Occupational Therapy 60 visits per year limit combined for Rehabilitative (physical, speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, physical and occupational therapies). | \$30 per visit | 20% after OON deductible is met |
| Other Services | | |
| Chiropractic Services (up to 30 visits per year for Rehabilitative chiropractic services, separate 30 visits per year limit for Habilitative chiropractic services.) | \$50 per visit | 20% after OON deductible is met |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|--|---|
| <p>Diabetic Equipment and Supplies</p> <p>For medically necessary covered insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$25 for an individual prescription of up to a 30-day supply.</p> <p>For medically necessary covered noninsulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$25 or an individual prescription of up to a 30-day supply.</p> <p>For medically necessary covered diabetes devices and diabetic ketoacidosis devices the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$100 for an individual prescription of up to a 30-day supply.</p> | <p>Supplies obtained from your Physician are subject to the applicable Physician Cost Share.</p> <p>Supplies obtained through the pharmacy are subject to the applicable Pharmacy cost share based on Tier.</p> | <p>20% after OON deductible is met</p> |
| <p>Durable Medical Equipment (DME)</p> | <p>\$0 copayment per item after INET deductible is met</p> | <p>20% after OON deductible is met</p> |
| <p>Home Health Care Services (up to 100 visits per year)</p> | <p>No Cost</p> | <p>20%</p> |
| <p>Outpatient Services (in a hospital or ambulatory facility)</p> | <p>Freestanding Facility: \$250 per service after INET deductible is met</p> <p>Hospital Based: \$500 per service after INET deductible is met</p> <p>Please refer to your provider directory to identify freestanding facilities and hospital-based</p> | <p>20% after OON deductible is met</p> |
| <p>Prosthetic Services</p> | <p>\$0 copayment per item after INET deductible is met</p> | <p>20% after OON deductible is met</p> |
| <p>Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all Inpatient settings.</p> | <p>\$0 copayment per admission after INET deductible is met</p> | <p>20% after OON deductible is met</p> |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|--|---|
| (skilled nursing facility stay and inpatient rehabilitation is limited to 90 days per year combined) | | |
| Emergency and Urgent Care | | |
| Ambulance Services Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> . | \$0 copayment per service after INET deductible is met | Same as INET |
| Emergency Room | \$150 per visit | Same as INET |
| Urgent Care Centers | \$75 per visit | 20% after OON deductible is met |

Important Information:

ADDITIONAL INFORMATION: MEDICAL SERVICES

What Will You Pay for Covered Health Care Services?

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Emergency Health Care Services – Outpatient

If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, 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.

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.

Benefit Limitations

The benefits listed below have the following limitations:

Outpatient Rehabilitation and Habilitative Services:

Post-Cochlear Implant Aural Therapy is limited to 60 visits per year for Rehabilitative post-cochlear implant aural therapy and a separate 60 visits per year limit for Habilitative.

Cognitive Therapy is limited to 60 visits per year for Rehabilitative cognitive therapy and a separate 60 visits per year for Habilitative.

Hearing aids

Hearing Aids will be covered once every 24 months.

The above limit does not apply to over-the-counter hearing aids. For over-the-counter hearing aids, Benefits are limited to \$1,000 every year. Benefits are further limited to a single purchase every year.

Fertility Preservation for Iatrogenic Infertility:

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.

Preimplantation Genetic Testing (PGT) and Related Services:

Benefit limits for related services will 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.

This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider*.

Pharmaceutical Products – Outpatient

Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical 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 Specialty Pharmaceutical Products and the applicable Co-payment and/or Co-insurance.

Accessing 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.

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*.

Does Prior Authorization Apply?

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

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.

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.

For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the

amount you are required to pay will be reduced by 50% of the Allowed Amount, however, the amount of the reduction will not exceed \$500 per occurrence.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply.

- **Ambulance** - 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.
- **Breast pumps.** For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.
- **Cellular and Gene Therapy** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises.
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.
- **Clinical trials.** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.
- **Congenital Heart Disease (CHD) Surgeries** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises
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.
- **Diabetes Services** For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes (either retail purchase cost or cumulative retail rental cost of a single item).
- **Durable Medical Equipment (DME), Orthotics and Supplies** For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than \$500 (either retail purchase cost or cumulative retail rental cost of a single item).
- **Fertility Preservation for Iatrogenic Infertility** For Out-of-Network Benefits, you must obtain prior authorization as soon as possible.
- **Gender Dysphoria** - For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises.

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*

- **Habilitative Services** 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.

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.

For Out-of-Network Benefits for outpatient therapies, you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment, speech therapy, post-cochlear implant aural therapy, and cognitive therapy or as soon as is reasonably possible.

- Home health care. For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.
- Hospice care 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.

In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.

- **Hospital - Inpatient Stay** - 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.

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.

- **Infertility services.** For Out-of-Network Benefits, you must obtain prior authorization as soon as possible.
- **Lab, X-Ray and Diagnostic – Outpatient** 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.
- **Major Diagnostic and Imaging – Outpatient** 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.
- **Mental Health Care and Substance-Related and Addictive Disorders Services** - 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 (prior authorization is not required for neuropsychological testing for children diagnosed with cancer).

In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

- **Obesity - Weight Loss Surgery** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of obesity - weight loss surgery arises.

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 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.

- **Pharmaceutical Products – Outpatient** For Out-of-Network Benefits, you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.

For Out-of-Network Benefits, you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. You may find out whether a particular Pharmaceutical Product requires prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

- **Pregnancy - Maternity Services-** 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.
- **Preimplantation Genetic Testing (PGT) and Related Services** For Out-of-Network Benefits, you must obtain prior authorization as soon as possible.
- Prosthetic devices. For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices.
- **Reconstructive Procedures-** 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.

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.

- Rehabilitation services and **Chiropractic Treatment** - physical therapy, occupational therapy, Chiropractic Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy. For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy or as soon as is reasonably possible.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic. For Out-of-Network Benefits, 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.
- **Skilled Nursing Facility and Inpatient Rehabilitation Facility services.** 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.

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 (including Emergency admissions).

- **Spine and Joint Surgeries** For Out-of-Network Benefits, you must obtain prior authorization for spine and joint surgeries.
- **Surgery – Outpatient** For Out-of-Network Benefits for all outpatient surgeries, 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.
- **Temporomandibular Joint (TMJ) Services** 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.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.

- **Therapeutic Treatments – Outpatient** For Out-of-Network Benefits, you must obtain prior authorization for all outpatient therapeutic services five business days before scheduled services

are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.

- **Transplantation Services** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

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.

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

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

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

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

Care Management

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

Special Note Regarding Medicare

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

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.

Allowed Amounts

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

- For Designated Network Benefits and 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*.

Designated Network Benefits and Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network Benefits and 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 Act with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

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

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

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The provider may bill us directly and we will reimburse the provider the greatest of the following amounts:
 - The amount we would pay for such services if rendered by an in-network health care provider;
 - The usual, customary and reasonable rate for such services; or
 - The amount Medicare would reimburse for such services.

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 140% 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.
 - 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. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

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

If you are diagnosed with a condition or disease that requires specialty care and either we do not have a Network provider with the required specialty training or if access to a Network provider would require unreasonable travel or delay, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and/or your Network Physician to coordinate care through an out-of-Network provider.

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.

II. ADDITIONAL INFORMATION: OUTPATIENT PRESCRIPTION DRUGS

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 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 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.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

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

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

Prescription Drug Tiers

Prescription Drug Products are categorized into cost tiers. Tier one contains lower cost generic drugs. Tier 2 contains preferred lower cost brand drugs. Tier 3 typically contains non-preferred brand drugs. Tier 4 typically contains higher cost brand drugs.

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.

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.

Prescription Drug Products which require prior notification are listed below.

Prescription Drug Products which require Notification: Absorica, Abstral, Actemra (subcutaneous formulation), Actimmune, Actiq, Adcirca, Adderall, Adderall XR, Adempas, Afinitor, Alecensa, Amitiza, Amnesteem, Ampyra, Aptiom, Arcalyst, Atralin, Aubagio, Avita, Avodart, Avonex, Banzel, Berinert, Betaseron, Bethkis, Bosulif, Brilinta, Bunavail, Caprelsa, Cayston, Cerdelga, Cholam, Cimzia, Cinryze, Claravis, Cometriq Compounds and Bulk Powders, Concerta, Copaxone, Cosentyx, Cotellic, Crinone, Cystaran, Daklinza, Daliresp, Daytrana, Desoxyn, Dextredreine, Dextrostat, Differin, Egrifta, Elidel, Eligard, Elocatate, Enbrel, Endometrin, Entresto, Epanova, Erivedge, Esbriet, Evekeo, Exjade, Extavia, Fabior, Farydak, Fentanyl citrate compounds, Fentora, Ferriprox, Firazyr, First Progesterone, Focalin, Focalin XR, Forteo, Fulyzaq, Fycompa, Gattex, Genotropin (excluded), Gilenya, Gilotrif, Gleevec, Grastek, H.P. Acthar, Harvoni, Hettioz, Humatrope (excluded), Humira, Hycamtin, Ibrance, Iclusig, Imbruvica, Increlex, Infergen, Inlyta, Intron A, Iressa, Jadenu, Jakafi, Jublia, Juxtapid, Kalydeco, Kerydin, Keveyis, Kineret, Kitabis Pak, Korlym, Kuvan, Kynamro, Lazanda, Lenvima, Letairis, Linzess, Lonsurf, Lotronex, Lovaza, Lynparza, Mekinist, Metadate, Metadate CD, Metadate ER, Movantik, Multaq, Myalept, Myorisan, Natpara, Nexavar, Ninlaro, NordiFlex, Norditropin (excluded), Nutropin, Nutropin AQ, Nutropin AQ NuSpin, Nuvigil, Odomzo, OFEV, Olysio, Omnitrope (excluded), Omtryg, Onfi, Opsumit, Oralair, Orenica (subcutaneous formulation), Orenitram, Orkambi, Otezla, Peg-Intron/Pegasys, Plegridy, Pomalyst, Potiga, Praluent, ProCentra, Procysbi, Promacta, Protopic, Porvigil, Pulmozyme, Quillivant XR, Ragwitek, Ravicti, Rebif, Rebif Rebidose, Rectiv, Regranex, Repatha, Restasis, Retin-A, Retin-A Micro, Revatio, Revlimid, Ritalin, Ritalin LA, Ritalin SR, Ruconest, Saizen, Sandostatin/octreotide, Selzentry, Serostim, Signifor, Simponi, Sirturo, Solaraze, Sotret, Sovaldi, Sprycel, Stelara, Stivarga, Stremsiq, Suboxone/Subutex, Subsys, Sutent, Sylatron, Syprine, Tafinlar, Tagrisso, Tarceva, Targretin, Tassigna, Tazorac, Tecfidera, Technivie, Temodar, Thalomid, TOBI, TOBI Podhaler, Tracleer, Tretinoin cream, Tretinoin gel, Tretin-X, Tykerb, Tyvaso, Upravi, Valchlor, Vascepa, Vecamyl, Ventavis, Victrelis, Viekira Pak, Vimpat, Votrient, Vyvanse, Xalkori, Xeljanz, Xtandi, Xyrem, Zelboraf, Zenatane, Zenzedi, Zomacton, Zontivity, Zorbitive, Zubsolv, Zydelig, Zykadia, Zytiga.

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* 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 or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

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

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

This step therapy process will not require you to use an alternative brand name prescription drug or over-the-counter drug prior to using a brand name prescription drug that has been prescribed by a licensed physician for pain treatment. We may require you to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug. Step therapy is not required for a prescribed drug for cancer treatment for a Covered Person who has been diagnosed with state IV metastatic cancer when the prescribed drug is in compliance with approved federal Food and Drug Administration indications.

Prescription Drug Products subject to step therapy requirements: H.P. Acthar, Cystagon, Depakote, Depakote ER, Stavzor, Keppra, Keppra XR, Lamictal, Lamictal ODT, Lamictal XR, Lamotrigine ER, Lamotrigine ODT, Neurontin, Tomamax, Trileptal, Oxtellar XR, Qudexy XR, Zonegran, Trokendi XR, Cialis (tadalafil) 2.5 & 5 mg, Bosulif, Sprycel, Xtandi, Amitiza, Brintellix, Fetzima, Inokana, Jardiance, Farxiga, Januvia, Janumet, Janument XR, Xigduo XR, Glyxambi, Trulicity, Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog Mix 70/30, Apidra, Apidra SoloStar, Afrezza, Oxistat, Jublia, Kerydin, Uloric, Nexium suspension (esomeprazole), Prevacid SoluTab (lansoprazole), Olysio, Sovaldi, Victrelis, Viekira Pak, Peg-Intron, Repatha, Lescol XL, Livalo, Stribild, Genvoya, Bravelle, Follistim AQ, Resulti, Rasuvo, Otrexup, Aubagio, Gilenya, Rebif, Rebif Rebidose, Extavia, Rescula, Travoprost (generic Travatan), Zioptan (tafluprost), Butrans, Embeda, Avinza, Exalgo, Hysingla, Kadian, MS Contin (Brand Only), Oxycontin, Oxymorphone hcl ER (generic Opana ER), Pancreaze, Pertzye, Ultresa, Viokace, Otezla, Xeljanz, Actemra, Orencia, Enbrel, Cosentyx, Lyrica, Cordran SP cream (flurandrenolide).05% cream), Cordran Lotion (flurandrenolide 0.05% lotion, Desonate (desonide 0.05% gel), Cloderm cream (clocortolone pivalate 0.1% cream), Halog cream (halcinonide 0.1%), Halog ointment (halcinonide 0.1% ointment), Soolantra, Belsomra, Rozerem, Zolpmist, Zovirax ointment.

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

What Do You Pay?

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any or Out-of-Pocket Limit.

The amount you pay for any of the following under the *Outpatient Prescription Drug Rider* will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- Ancillary Charges.
- 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.

Certificate of Coverage

Oxford Health Insurance, Inc.

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between Oxford Health Insurance, Inc. 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 Connecticut. The Policy is subject to the laws of the state of Connecticut and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Connecticut 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 Oxford Health Insurance, Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 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

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

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

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

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

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. 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.

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.

Certificate of Coverage Table of Contents

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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 or are state/federally mandated:

- 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 requirements specified in the Policy.

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

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

1. Abortion Services

Benefits include services for a therapeutic abortion, that is an abortion recommended by a Provider performed to save the life or health of the mother, or as a result of incest or rape. The plan will also cover elective abortions.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the 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.

3. 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*.

4. 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.
- Disabling or life-threatening chronic disease.

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - 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 patient care costs are subject to the terms, conditions, restrictions, exclusions and limitations of this Policy. If treatment is not available at an in-network facility, coverage may be provided at an Out-of-network hospital at no greater cost than if such treatment was available in-network.

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 disabling or 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 disabling or life-threatening diseases or conditions. 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 disabling or life-threatening diseases or conditions, 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 disabling or life-threatening diseases or disorders. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)* .)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

5. Dental Services - Accident Only

Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair (not replacement) of sound natural teeth when both of the following are true:

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

Please note that dental damage that happens as a result of normal activities of daily living (such as biting or chewing) or intentional misuse 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 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 include the following:

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

6. Diabetes Services

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

Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes.

Coverage includes:

- Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to:
- Counseling in nutrition.
- The use of equipment and supplies
- Training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes.
- Training and education, up to four hours, because of the development of new techniques and treatments.

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

Diabetic Self-Management Items

Insulin pumps, supplies and medications for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps which are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment.
- Insulin.
- Oral agents such as glucose tablets and gels.
- Glucagon for use with injection to increase blood glucose concentration.
- Blood glucose meters including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

If your Benefit plan includes an *Outpatient Prescription Drug Rider*, Benefits for diabetic medications and supplies may be provided as described in the Outpatient Prescription Drugs section of the *Schedule of Benefits*.

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 *Devices, Appliances, Medical Equipment and Prosthetics*.

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

8. Emergency Health Care Services - Outpatient

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

Coverage includes Emergency Health Care Services due to accidental ingestion or consumption of a controlled drug. A "controlled drug" is a substance such as cocaine, morphine, hallucinogens, etc. It does not include alcohol, nicotine or caffeine.

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). This also includes coverage for isolation care and emergency services provided by the state's mobile field hospital.

Benefits do not include follow-up care provided in a Hospital Emergency room.

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions.

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 are provided for pharmaceutical products related to the treatment of fertility preservation that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or your home and as described under your *Outpatient Prescription Drug Rider*.

Benefits are not available for embryo transfer.

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

11. Gender Dysphoria

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

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

12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed 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.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

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.

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

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

14. Home Health Care

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

- Ordered by an advanced practice registered nurse (APRN), or a Physician.
- Provided in your home by a registered nurse, or advanced practice registered nurse (APRN), or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available for:

- Part-time intermittent home nursing care by or supervised by a registered professional nurse.
- Part-time or intermittent home health aide services.
- Home Health Agency services include physical, occupational or speech therapy.
- Benefits are available for the following items to the extent that they would have been available if the Covered Person were confined to a Hospital:
 - Medical supplies.
 - Drugs and medicine.
 - Laboratory services.
 - Medical social services, including but not limited to those provided to or for the benefit of a Covered Person diagnosed by a Physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live. Medical social services are services, rendered under the direction of a Physician or an advanced practice registered nurse, by a qualified social worker. These services include, but are not limited to:
 - Assessment of the social, psychological and family problems related to or arising out of such Covered Person's illness and treatment.
 - Appropriate action and utilization of community resources to assist in resolving such problems.
 - Participation in the development of the overall plan of treatment for such Covered Person.

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 including radiologists, anesthesiologists, pathologists and Emergency room Physicians.

We will pay Benefits for an Inpatient Stay of at least 48 hours following a mastectomy or lymph node dissection. We will pay Benefits for a longer Inpatient Stay if it is recommended by the Physician after conferring with the patient.

17. Infertility Services

Services for the treatment of infertility when provided by or under the direction of a Physician.

For the purpose of this benefit, infertility is defined as the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

Coverage must be provided for the expense for the diagnosis and treatment of infertility, including but not limited to:

- Ovulation induction.
- Intrauterine insemination.
- In-vitro fertilization.
- Uterine embryo lavage.
- Embryo transfer.
- Gamete intra-fallopian transfer (GIFT).
- Zygote intra-fallopian transfer (ZIFT).
- Low tubal ovum transfer.

Benefits for infertility include but are not limited to the following:

- Ovulation induction is limited to a maximum benefit of four cycles;
- Intrauterine insemination is limited to a maximum benefit of three cycles;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to a maximum of two cycles, with no more than two embryo implantations per cycle;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful;

Covered Health Care Services must be performed at facilities that conform to the standards of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

18. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Additional screenings and services to monitor for breast cancer and other gynecological cancers may be considered preventive care services under state law. When applicable, They are covered with no Copayments or Coinsurance, however your Deductible may apply.
- These may be available to you, if you are believed to be at an increased risk due to:
 - A family history, or
 - A prior personal history of breast, ovarian, or certain related cancers, or
 - If the treatment of a childhood cancer has increased your risk of breast cancer, or

- A positive genetic test for gene variants that increase your risk to certain cancers, or
- Other indications as determined by the insured's physician, advanced practice registered nurse, physician assistant, certified nurse midwife or other medical provider.
- Requirements for each screening or service may vary and may be subject to Medical Necessity review.
- Diagnostic and screenings services may include, but may not be limited to:
- Mammograms, including mammograms provided by Breast Tomosynthesis.
- Comprehensive Ultrasound screening of an entire breast or breasts [if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
- Magnetic Resonance Imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.
- Mastectomies intended to prevent disease (prophylactic mastectomy).
- Genetic Testing.
- Routine screening procedures and surveillance tests for ovarian cancer.
- 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*.)
- Prostate Specific Antigen (PSA) tests to screen for prostate cancer for men who are symptomatic or whose biological father or brother has been diagnosed with prostate cancer and for all men fifty years of age or older. The treatment of prostate cancer is covered provided such treatment is medically necessary and in accordance with guidelines established by the *National Comprehensive Cancer Network*, the *American Cancer Society* or the *American Society of Clinical Oncology*.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

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*.

19. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services including radiologists, anesthesiologists and pathologists.

20. Medical Supplies

Benefits for medical supplies for Covered Health Care Services required for the treatment of Sickness or Injury. This includes maintenance supplies, such as ostomy supplies.

Benefits for diabetic supplies are described under *Diabetes Services*. Benefits for supplies associated with DME are described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

21. Mental Health Care Services

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

Two wellness exams per year conducted by a licensed mental health professional or primary care provider, these exams will be conducted at no cost to the member, (no Coinsurance, Copayments, or deductibles), and Prior Authorization is not required for these 2 exams.

Benefits include the following levels of care:

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.
- Intensive, home-based or evidence-based services designed to address specific mental or nervous conditions in a child or adolescent while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's, adolescent's, and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.
- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities.
- Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician, or advanced practice registered nurse (APRN) and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:

- The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, advanced practice registered nurse (APRN), psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
- Extended day treatment programs.

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 include the following levels of care:

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

Services include the following:

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

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA).

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

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

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

22. Oral Surgery

The following limited dental and oral surgical procedures in either an inpatient or outpatient setting:

- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Removal of cysts related to teeth is not covered.

- Surgical and nonsurgical medical procedures for temporomandibular joint (TMJ) disorders and orthognathic surgery.

23. Orthoptic Exercises and Corneal Topographic Procedures

Orthoptic exercises for the treatment of the following conditions:

- Amblyopia for Covered Persons up to age 19. Treatment includes patching and penalization therapies.
- Convergence insufficiency.

Corneal topographic procedures for the treatment of certain conditions.

24. Ostomy Supplies

Benefits for Medically Necessary appliances and supplies relating to an ostomy include, but are not limited to, the following:

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

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

25. Pharmaceutical Products – Outpatient

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

Benefits are provided for Pharmaceutical Products which, due to their 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 may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

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

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

Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Co-payment and/or Co-insurance, you may receive Pharmaceutical Products 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 order or refill and/or the amount dispensed per month's supply.

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

Certain Specialty Pharmaceutical Products are eligible for coupons or offers 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 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 Specialty Pharmaceutical Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Schedule of Benefits*.

26. 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 allergy testing and treatment, including routine allergy injections.

Immunization coverage and 20 minute immunization consultation between Member and the Physician.

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

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

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

27. Pregnancy - Maternity Services

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

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

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

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

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

If discharge occurs earlier than these timeframes, we will pay Benefits for a follow-up visit within 48 hours of discharge and an additional follow-up visit within seven days of discharge.

Follow-up services will include, but not limited to, the following:

- Physical assessment of the newborn.
- Parent education.
- Assistance and training in breast or bottle feeding, which is covered as long as Medically Necessary and is not limited to the follow-up visit within 48 hours of discharge or the additional follow-up visit within 7 days of discharge.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests.

Follow-up services must be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations. Follow-up services must be provided by a qualified health care personnel trained in post-partum maternal and newborn pediatric care.

28. 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).

29. 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*.
- 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. 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.

30. 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, Medical Equipment and Prosthetics*.

31. Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be Medically Necessary by the Physician.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of

complications, 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.

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

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

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

Benefits are not available for maintenance/preventive treatment.

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

33. Second and Third Opinions

Second and third opinions requested by you or by us.

At your request:

- If you disagree with a Network provider's recommended course of treatment, you may request that another provider render a second opinion.
- If the first and second opinions do not agree, we will designate a Network provider to render a third opinion at no cost to you.
- After reviewing the third opinion, we will cover the Covered Health Care Services supported by a majority of the providers reviewing your case.
- If the first opinion concerns a diagnosis of cancer (either negative or positive) or treatment for cancer, you may obtain a second opinion from an out-of-Network provider on a Network basis.

At our request:

- We reserve the right to require a second opinion for any surgical procedure.

- If a second surgical opinion is required, we will refer you to a Network provider for the second opinion at no cost to you.
- In the event that the first and second surgical opinions differ, a third opinion will be required. We will designate another Network provider for a third opinion at no cost to you.
- The third opinion will determine whether the procedure will be covered. The providers who render the second or third opinion are not eligible to perform the procedure.

34. 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 including radiologists, anesthesiologists and pathologists.

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.

35. Substance-Related and Addictive Disorders Services

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

Two wellness exams per year conducted by a licensed mental health professional or primary care provider, these exams will be conducted at no cost to the member, (no Coinsurance, Copayments, or deductibles), and Prior Authorization is not required for these 2 exams.

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.

- Intensive, home-based services designed to address specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.
- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities. Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:
 - The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
 - Extended day treatment programs.
 - Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities.
 - Observation beds in acute hospital settings.
 - Psychological and neuropsychological testing conducted by an appropriately licensed health care provider.
 - Trauma screening conducted by a licensed behavioral health professional.
 - Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional.
 - Substance use screening conducted by a licensed behavioral health professional.

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

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

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

36. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Sterilization. Note: Sterilization for women is not subject to cost share.
- Physician services including radiologists, anesthesiologists and pathologists.
- Please refer to our provider directory located on our website at www.myuhc.com for assistance with identifying the different types of facilities.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Included under this section is coverage for colorectal cancer screenings, including, but not limited to annual fecal occult blood test, colonoscopy and flexible sigmoidoscopy/radiologicimaging in accordance with the recommendations established by the *American Cancer Society*. There is no cost share when more than 1 colonoscopy is ordered in a policy year.

37. Termination of Pregnancy

Therapeutic abortions and abortions in the case of rape, incest or fetal malformation. Elective abortions are covered. Benefits are limited as stated in the *Schedule of Benefits*.

38. Telehealth Services

Telehealth services are covered when services are received for the diagnosis, prevention, treatment, cure or relief of a physical or mental health conditions, illness, injury or disease. These services are covered to the same extent that the same services would be covered if received during a face to face consultation. The cost share for Telehealth services will be based on the type of provider who rendered the services (Primary Care Physician, Specialist, registered nurse or advanced practice registered nurse), as outlined in your Summary of Benefits. If these services are received from a network Telehealth provider, they will be covered at the network level of benefits, and if received from an Out-of-Network provider, they will be covered at the Out-of-Network level of benefits.

Physicians and APRNs to certify a qualifying patient's use of medical marijuana and provide follow -up care via telehealth.

For purposes of this Benefit, "Telehealth" means the mode of delivering health care or other health care services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a covered member's physical and mental health and includes:

- Interaction between the patient at an originating site and the Telehealth provider at a distant site, and
 - Synchronous interactions, asynchronous store and forward transfers or remote monitoring.
- Telehealth does not include the use of facsimile, texting or electronic mail.

39. Temporomandibular Joint Services

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

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

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

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

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

Non-surgical treatment including, but not limited to, appliances, behavior modification, physiotherapy and prosthodontic therapy is not covered.

40. Therapeutic Treatments - Outpatient

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

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

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 including anesthesiologists, pathologists and radiologists.
- Sleep studies.

Two wellness exams per year conducted by a licensed mental health professional or primary care provider, these exams will be conducted at no cost to the member, (no Coinsurance, Copayments, or deductibles), and Prior Authorization is not required for these 2 exams.

41. Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.

- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs 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.

Human leukocyte antigen testing or histocompatibility locus antigen testing for A, B and DR antigens (testing to determine the compatibility for bone marrow transplants). The bone marrow testing must be performed at a facility certified under the federal Clinical Laboratory Improvement Act and accredited by the American Society for Histocompatibility and Immunogenetics. Enrollees must register for the National Marrow Donor Program when being tested.

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

- Transportation, Lodging and Meal Expenses for Transplants
- Expenses for transplantation, lodging, and meals for the transplant recipient and his or her companion are reimbursable per transplant episode.
- A “transplant episode” is the time from the initial evaluation for the transplant until 90 days after the recipient is discharged from the transplant facility or until the recipient is cleared to return home, whichever is sooner.
- The transplant facility must be more than 300 miles from the transplant recipient’s home for this reimbursement to apply.
- Transportation costs incurred for travel to and from the transplant facility for the transplant recipient and one other individual accompanying the recipient are covered.
- If air transportation is chosen, coverage includes round trip transportation for the transplant recipient and one other individual accompanying the recipient up to two round trips per person.
- If travel occurs via automobile, mileage will be reimbursed based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was undertaken for a maximum of one round trip from the transplant recipient’s home to the transplant facility.
- Transportation, lodging and meal receipts must be submitted to us at the appropriate address listed in the information you receive from us when authorizing this reimbursement.
- There is no coverage for the following expenses:
 - Any expenses for anyone other than the transplant recipient and the designated traveling companion.

- Any expenses other than the transportation, lodging and meals described in this provision.
- Local transportation costs while at the transplant facility.
- Rental car costs.

42. 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*.

43. Virtual Care Services

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

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

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email or fax, or for services that occur within medical facilities.

44. Wigs

Wigs and other scalp hair prosthesis for a Covered Person who suffers hair loss as a result of chemotherapy when prescribed by a licensed oncologist.

Additional Benefits Required By Connecticut Law

45. Craniofacial Disorders

Benefits for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Covered Persons eighteen years of age or younger when prescribed by a craniofacial team recognized by the *American Cleft Palate Craniofacial Association*. This does not provide coverage for cosmetic surgery.

46. Dental Services

Surgery, general anesthesia, nursing and associated Hospital or Alternative Facility services provided in conjunction with inpatient, outpatient or one-day dental services when the dentist or oral surgeon and the Physician determine that the services are Medically Necessary for the treatment of either of the following types of patient:

- A person who is determined by a dentist, in conjunction with a Physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- A person who has a developmental disability, as determined by a Physician who specializes in primary care that places the person at serious risk.

47. Developmental Needs of Children & Youth with Cancer

- Neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in children due to chemotherapy or radiation treatment.

48. Early Intervention Services

- Coverage for early intervention services provided as part of an individualized family services plan as defined by Connecticut law for a child from birth until the child's third birthday.
- Turns three years of age on or after May first and not later than the first day of the next school year commencing July first.
- Early intervention services are not subject to co-insurance, co-payments, deductibles or other out-of-pocket expenses, regardless of whether the provider is a Network or Out-of-Network provider.

49. Lyme Disease Services

Coverage for Lyme disease treatment, including but not limited to up to 30 days of intravenous antibiotic therapy and/or sixty days of oral antibiotic therapy and further treatment will be provided if recommended.

50. Medical Foods

Coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the treatment of inherited metabolic diseases and are administered under the direction of a Physician.

In addition, coverage must be provided for specialized formulas when they are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician.

Inherited metabolic diseases - a disease for which newborn screening is required under section 19a-55 of the general statutes of Connecticut and cystic fibrosis.

Amino acid modified preparation - a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Specialized formula - a nutritional formula for children up to the age of twelve years of age that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

51. Nutritional Counseling

Nutritional Counseling is a Covered Health Care Service for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity. In addition, the services must be prescribed by a licensed health care professional and provided by a certified, registered or licensed health care professional in a physician's office or outpatient facility.

52. Pain Management

Covered Health Care Services received by a pain management specialist for pain treatment which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

53. Wound Care Supplies

Wound care supplies for the treatment of epidermolysis bullosa when administered under the direction of a Physician. Epidermolysis bullosa is a rare inherited genetic disorder caused by a mutation in the keratin gene. The disorder is characterized by the presence of extremely fragile skin and recurrent blister formation, resulting from minor mechanical friction or trauma. The resulting wounds require continuous treatment.

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. This exclusion does not apply to acupressure and acupuncture services for which Benefits are available as described under *Pain Management* in *Section 1: Covered Health Care Services*.
2. Aromatherapy.
3. Hypnotism.
4. Rolfing.
5. Wilderness, adventure, camping, outdoor, or other similar programs.
6. 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). This exclusion does not apply to services for which Benefits are provided as described under in *Section 1: Covered Health Care Services*.

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

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Removal of teeth (including wisdom teeth).
- 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*.

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.
6. Removal of cysts related to teeth.

C. Devices, Appliances, Medical Equipment 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.
 8. Powered and non-powered exoskeleton devices.
 9. 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*.
 10. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
 11. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to medications covered under *Section 1: Covered Health Care Services*.
2. Self-administered or self-infused medications. This exclusion does not apply to medications covered under *Diabetes Services* in *Section 1: Covered Health Care Services*. 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.
3. Over-the-counter drugs and treatments.
4. Growth hormone therapy.
5. 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*.
6. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
7. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological

Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

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

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 or preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Care Services.

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. Mental Health Care Services

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

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

I. 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.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - 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, escalators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers or water purifiers.
 - Jacuzzis.
 - Mattresses or waterbeds.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Safety equipment.
 - Saunas.
 - Stair lifts and stair glides.

- Strollers.
- Swimming pools.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

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

The exception to this is the removal of a breast implant which was implanted on or prior to July 1, 1994, without regard to the purpose of such implantation.
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 control. All services, supplies, programs and surgical procedures for the purpose of weight control, except surgical procedures that are Medically Necessary for the treatment of morbid obesity.
6. Wigs, except as required for hair loss due to chemotherapy as described in *Section 1: Covered Health Care Services*.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
8. Biofeedback, except as required for treatment of Urinary Incontinence.
9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; and dental restorations. Medically Necessary TMJ services for surgical medical and dental should be covered.
10. Non-surgical treatment of obesity.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
13. Intracellular micronutrient testing.
14. Cellular and Gene Therapy services not received from a Designated Provider.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal 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.
4. No-show charges. If a provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

N. Reproduction

1. The following infertility treatment-related services:

- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, testicular tissue, and ovarian tissue, unless harvesting eggs for surrogate is a covered expense if harvested from the member.
 - Donor services.
2. The following services related to a Gestational Carrier or Surrogate:
- All costs related to reproductive techniques including:
 - ◆ Assisted Reproductive Technology (ART).
 - ◆ Artificial insemination.
 - ◆ Intrauterine insemination.
 - ◆ Obtaining and transferring embryo(s).
 - ◆ Preimplantation Genetic Testing (PGT) and related services.

The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care 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. The reversal of voluntary sterilization.
5. Elective fertility preservation.
6. In vitro fertilization that is not used as an Assisted Reproductive Technology for the treatment of infertility. 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*.

O. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Except as otherwise provided under Conn. Gen. Stat. Section 38a – 527, health care services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements.

Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

P. Substance-Related and Addictive Disorders Services

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

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

Q. Transplants

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

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other 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* or 2) transportation, lodging and meal expense for which Benefits are provided as described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain, unless such treatment is Medically Necessary and has been ordered by a pain management specialist.
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.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
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. 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.
5. 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.

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

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.

- Described as a Covered Health Care Service in this Certificate under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
 3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
 7. Follow-up care provided in a Hospital Emergency room.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Blood, blood plasma, blood derivatives and synthetic blood. This exclusion does not apply to services that are covered in *Section 1: Covered Health Care Services*. Apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not covered.
 10. Routine harvesting and storage of stem cells from newborn cord blood.
 11. Autopsy.
 12. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
 13. Services or supplies that have been fraudulently obtained.
 14. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

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.

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other.

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

- Birth for the first 61 days even when no dependent coverage is purchased.
- Legal adoption.
- Placement for adoption.
- Marriage or Civil Union.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the event.

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.

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 birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day 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. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health 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). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

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

If the Group terminates you for any reason other than a layoff or relocation or closing of a covered establishment, or if you voluntarily leave your place of employment, the Group may decide to not pay the premium for you and your Enrolled Dependents after the date of termination. If the Group makes this election, the Group must:

- Notify us within 72 hours of the termination of your employment so that we may process the request; and
- Notify you of the termination of health care coverage
- When the Group has exercised this election and has provided the required notices, your coverage will terminate three calendar days after termination of employment. It is the Group's responsibility to remit to you your portion of the credited premium.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

Dependent coverage will end on the policy anniversary date after the Dependent reaches age 26.

- **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. The Group can provide you with specific information on which of these dates apply.

- **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. The Group can provide you with specific information on which of these dates apply.

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

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 31 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.

During the first two years the Policy is in effect, 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.

Notice of Termination

The Group must furnish each Subscriber notice of the termination of this Policy. The notice will be mailed or delivered to the Subscriber not less than fifteen days preceding the effective date of the termination. The notice is not required if the Group replaces this Policy with another group health insurance policy without interruption of coverage. If the Group fails to furnish the notice, the Group will be liable for benefits to the same extent as we would have been liable if the Policy had not been terminated.

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

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

Continuation 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 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 to find out if your Group is subject to the provisions of *COBRA*.

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

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

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

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

Continuation Coverage under State Law

Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage ends and if your coverage ends under the Policy as described below. This continuation applies to you if the Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Groups that are not subject to the terms of *COBRA*. You should call your Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.
- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.

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 180 days 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.

If a provider of ambulance services complies with the statutory provision for direct payment and that provider has not been paid from any other source, Allowed Amounts due to that provider will be paid directly to that provider instead of being paid to the Subscriber.

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.

If your Benefit plan includes an *Outpatient Prescription Drug Rider* and you need to file a claim, your claim should be submitted to:

Optum RX
PO Box 650629
Dallas, TX 75265-0629

Payment of Benefits

When you receive Covered Health Care Services from an Out-of-Network provider, we may reimburse you directly, less any applicable Annual Deductible, Co-payment and any amount that exceeds Allowed Amounts and you will then be responsible for reimbursing the Out-of-Network provider. The reimbursement will be based on the definition of Allowed Amounts as described under *Section 9: Defined Terms*. You may assign your right to reimbursement under this Certificate to a dentist or oral surgeon provided (1) the dentist or oral surgeon does not charge you more than what the dentist/oral surgeon would charge an uninsured patient for the same services, and (2) the dentist or oral surgeon allows Us to review medical records, with at least 48 hours notice, during regular business hours. For all other types of providers, you may not assign your right to reimbursement under this Certificate to an Out-of-Network provider without our consent. We may, however, in our discretion, pay an Out-of-Network provider directly for services rendered to you.

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.

When claims are received via paper format, we will pay Benefits within 60 days after we receive your request for payment that includes all required information. When claims are received via electronic format, we will pay Benefits within 20 days after we receive your request for payment that includes all required information.

In a case where our obligation to pay a claim is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the Benefits covered under the Policy, or the manner in which services were accessed or provided, we will pay any undisputed portion of the claim in accordance with the 60/20 day time period and notify you in writing within: 1) 30 days of the receipt of the paper claim; or 2) 10 days of receipt of an electronic claim:

- that we are not obligated to pay the claim, stating the specific reasons why we are not liable; or
- to request all additional information needed to determine liability to pay the claim.

Upon receipt of the required information we will process the claim.

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

How Do You Appeal a Claim Decision?

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.

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 can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- 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.

This section describes the process for appealing a (1) utilization review (UR) decision or (2) a benefit, network or administrative decision. The process you will need to use depends upon the type of issue you are trying to resolve. Please read the information in the section carefully, as it describes what the different review procedures are and when and how to use them. If you are still not sure of the process to follow, contact us at the telephone number shown on your ID card.

Copies of these procedures are available in many languages and can be forwarded to you subject to availability. We can also arrange to have an independent interpreter available, however our ability to provide this service depends on the availability of the interpreter. We may need to arrange to call you at a

time when an interpreter is available. Additionally, you always have the right to designate a representative during this process.

Authorized Representatives

You have the right to use these procedures. It is your responsibility to begin a complaint or appeal within the timeframes set forth in this *Certificate*.

You may designate a person to act on your behalf, including your healthcare provider ("authorized representative"). For appeals of benefit determinations concerning urgent care, we are required to allow your healthcare provider, with knowledge of your condition, to act as your authorized representative without your written consent. A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without care or treatment that is the subject of the determination.

For all other circumstances, to authorize a representative to act on your behalf, you must provide us with written consent at the time your complaint or appeal is submitted. Because your medical records are privileged and confidential, and we want to ensure that you wish to appeal, you must submit an original signed written consent. Covered Person(s) who are 18 years of age or older, including a member's spouse or children, will need to provide their own signed written consent. If the member is a minor, a written consent must be signed by the member's parent or guardian.

Your authorized representative will only be authorized to act on your behalf and is required to comply with all of the conditions of your Certificate that would apply to you when you begin any appeal or complaint. Your authorized representative is not entitled to obtain any benefits or rights under your Certificate.

Utilization Review (UR) Appeals

UR will happen whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. The utilization review appeals process should be used after you have received an initial adverse UR determination and you do not agree with our decision. All appeals are subject to a review by us to evaluate the medical necessity of the services. You may use this process to appeal adverse determinations relating to all UR determinations, regardless of whether the services requested by you or your authorized representative have not yet been rendered (pre-service), are currently being rendered (concurrent) or have already been rendered (post-service).

Please note: This UR appeals process should not be used for appeals relating to benefit, network or administrative issues.

UR appeals must be within 180 days from receipt of an adverse determination (i.e., receipt of the determination notice). A decision may be rendered within the standard timeframes or may be expedited as described in this section.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Unless we have already issued a written determination, we will use our best efforts to provide written acknowledgement of the receipt of your appeal within 5 business days, but in no event later than 15 calendar days. Our decision to either uphold or reverse the adverse determination will be made and communicated to you as follows:

- Request for service (pre-service): Within 30 calendar days of our receipt of the appeal.

- Concurrent services for a member in an ongoing course of treatment (concurrent): Within 30 calendar days of our receipt of the appeal. In this instance, treatment will be continued without liability while your appeal is being reviewed.
- Coverage for services rendered (post-service): Within 60 calendar days of our receipt of the appeal.
- If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.
- This will be our final adverse determination. If you are not satisfied with our decision, you have the option of filing an external appeal (explained in the section below, "External Appeals.")

Expedited/Urgent Utilization Review (UR) Appeals

You can expedite your UR appeal when:

- You receive an adverse determination involving continued or extended health care services, procedures or treatments or additional services while you are undergoing a course of continued treatment (concurrent) prescribed by a health care provider; or
- The timeframes of the non-expedited UR appeal process would seriously jeopardize your life, health or ability to regain maximum function; or
- In the opinion of a Physician with knowledge of the health condition, the timeframes of the non-expedited UR appeal process would cause you severe pain that cannot be managed without the care of treatment that was requested; or
- Your Physician believes an immediate appeal is necessary because the timeframes of the non-expedited UR appeal process would significantly increase the risk to your health; or
- For Mental Health and Substance-Related and Addictive Disorders, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.
- You have two available options for expedited reviews. **These options are not available for Covered Health Care Services that have already been rendered (post-service).**

1. Internal Expedited UR Appeal: This process includes procedures to facilitate a timely resolution of the appeal including, but not limited to, the sharing of information between your provider and us by telephone or facsimile. We will provide reasonable access to our clinical peer reviewer within one business day of receiving notice of an expedited UR appeal.

A decision will be rendered and communicated for an internal expedited UR appeal within the following timeframes:

- 24 hours from our receipt of the appeal when the service being appealed is for Substance-Related and Addictive Disorders or co-occurring mental disorder, and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the Covered Person requiring an inpatient setting in connection with a Mental Illness.
- Forty-eight hours or seventy-two hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend from our receipt of the appeal for all other types of services.

If you are not satisfied with the outcome of the expedited UR appeal, you may further appeal through the external appeal process. If we do not make a determination within forty-eight hours or seventy-two after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend, the adverse determination will be reversed. The notice of an appeal determination will include the reasons for the determination. If the adverse determination is upheld on appeal, the notice will include the specific

reason(s) and clinical rationale used to render the determination, a reference to the specific health benefit plan provisions on which the decision is based, a statement that you may receive from us, upon request and free of charge, reasonable access to and copies of all relevant documents. We will also include a notice of your right to begin an external appeal. A description of each process and associated timeframes will be included. If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.

2. External Expedited Appeal: You also have the option to seek review by an independent review organization (IRO) in Emergency or life-threatening circumstances. You may make a request to the Commissioner of Insurance for an expedited external appeal without first completing the internal appeals process if:

- The timeframe for completion of an expedited internal appeal may cause or exacerbate an Emergency or life-threatening situation; or
- For a Mental Health Care and Substance-Related and Addictive Disorders, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a Covered Person from requiring an inpatient setting; and
- You, or your provider acting on your behalf with your consent, have filed a request for expedited internal review.

If you choose this option, you must submit the appeal by contacting the Connecticut Insurance Department at P.O. Box 816, Hartford, CT 06142-0816 (telephone number: 860-297-3910). For more information on how to file an expedited external appeal, refer to External UR Appeals below.

Office of the Healthcare Advocate and the Division of Consumer Affairs

If we deny a requested service on the basis that the service is not Medically Necessary or because it is a Certificate exclusion and you believe you have been given erroneous information, you have the right to contact either *Connecticut's Office of the Healthcare Advocate* or the *Division of Consumer Affairs* for assistance. You may contact them at the address listed below:

State of Connecticut

Office of the Healthcare Advocate

P.O. Box 1543

Hartford, CT 06114

Telephone: 1-866-466-4446

E-mail: Healthcare.advocate@ct.gov

Consumer Affairs Division

P.O. Box 816

Hartford, CT 06142-0816

Telephone: 1-800-203-3447

E-mail: cid.ca@ct.gov

External UR Appeals

Under certain circumstances, you or, with your consent, your authorized representative or provider acting on your behalf, have a right to file an external appeal or expedited external appeal for the denial of coverage for services based on lack of Medically Necessary criteria or because the service is

Experimental or Investigational for a particular medical condition. Benefit or administrative determinations are not eligible for external appeal; only utilization review issues are eligible for external appeal.

You or your authorized representative have the right to request an external UR appeal in the following situations:

- The service, procedure or treatment must otherwise be a Covered Health Care Service under this *Certificate*; and
- You must have received a final adverse determination through the UR appeals review, with a denial based on lack of Medical Necessity criteria or Experimental or Investigational Service(s) treatment UNLESS it is determined that the timeframe for completion of an internal appeal may cause or exacerbate an Emergency or life threatening situation. In an Emergency or life-threatening situation, you or your authorized provider acting on your behalf with your consent would not need to complete the internal UR appeal in order to file for an external appeal.

How to File an External Appeal

To file an expedited external appeal, you can submit an application with the Connecticut Insurance Department immediately following receipt of our initial adverse determination or appeal determination.

If the expedited external appeal is not accepted on an expedited basis, and you have not previously completed the internal UR appeal process, you may resume the internal appeal process until all internal appeals are exhausted. You may then file for a standard external appeal within 120 days following receipt of the final denial letter.

If the internal appeals were previously exhausted, your rejected expedited appeal will automatically be eligible for consideration for standard external appeal. You are not required to submit a new application.

Remember: You may not file an expedited external review for services which have already been provided (post-service).

To file a non-expedited external appeal, you have 120 days to begin the appeal through the State of Connecticut Insurance Department after you have completed the internal UR appeal or after We and you both agree to waive the internal appeal process

Requests for external appeals and expedited external appeals must be in writing on an external appeal application form. The application form will include instructions on how to complete and submit the form to the Commissioner. You or your authorized representative (and Provider, if applicable) must release all pertinent medical information concerning your medical condition and request for services. You may contact Connecticut's Insurance Department at the following address or telephone number:

Connecticut Insurance Department

PO Box 816

Hartford, CT 06142-0816

Attn: Utilization Review Nurse Coordinator

(860) 297-3910

For Overnight delivery only, please send Your application for External Review to:

State of Connecticut Insurance Department

153 Market Street

P.O. Box 816

Hartford, CT 06142-0816

860-297-3910

The following items must be included in your Appeal. Your Appeal will be rejected if all of these items are not included:

- A completed "request for External Appeal" form.
- An authorization form allowing us and your health care professional to release your medical information to the independent review organization.
- Evidence of being an enrollee of the plan (photocopy of your insurance card).
- Copies of all correspondence from us.
- A copy of the final determination letter indicating that all internal appeal mechanisms have been exhausted.
- A copy of your policy or certificate of coverage.

In addition to the required items outlined above, you may also submit any additional information relevant to your condition.

Following receipt of the request for external appeal or expedited external appeal, the covered person or the covered persons authorized representative has filed and will forward the appeal to us so that we may confirm that your appeal is complete and satisfies the conditions listed below. We will complete this review within 5 business days for an external review request or within 1 day for an expedited external review request.

1. You are or were a member of the plan at the time of the event that is subject of the adverse determination.
2. The service in question reasonably appears to be a covered service under the Certificate but was denied because it does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
3. The service in question reasonably appears to be a covered Service under the Certificate but was denied because it is experimental or investigational for a particular medical condition, is not explicitly listed as an excluded benefit under your health benefit plan and your treating health care professional has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving your medical condition;
 - Standard health care services are not medically appropriate for you.
 - There is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment.

In addition, your treating health care professional:

- recommended a health care service or treatment that he/she certifies, in writing, is likely to be more beneficial to you, in his/her opinion, than any available standard health care services or treatments; or
 - Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat your condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the denied health care service or treatment is likely to be more beneficial to you than any available standard health care services or treatments.
4. You have completed both at least the First Level Appeal process;
 5. You have provided all of the required information

Once we have completed our review, we will notify you, your authorized representative (if appropriate) and the Insurance Commissioner whether the appeal is complete and eligible for external review. We will communicate our findings in writing within 1 business day for an external appeal or on the day the review is completed for an expedited external appeal. If your appeal is not complete, the notice will include what

information or materials are missing. If your appeal is not eligible, the notice will include the reason(s) it is not eligible. In either instance, you may appeal this determination to the Insurance Commissioner.

If the external review or the expedited external review is accepted, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the health carrier shall include in such notice a statement that the covered person or the covered person's authorized representative may submit, not later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, additional information in writing to the assigned independent review organization that such organization shall consider when conducting the external review, and (ii) where and how such additional information is to be submitted. If additional information is submitted later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information

We will forward the medical and treatment plan records we relied upon in making our determination to the Independent Review Organization. If the documentation represents a material change from the documentation upon which we based our adverse determination or denial, we will have the opportunity to consider the documentation and amend or confirm our adverse determination or denial. This review will not delay or terminate the external review.

The Independent Review Organization will make a determination with regard to the appeal within the following timeframes:

- External Reviews: within 45 days after assignment from the Commissioner
- External Review involving an experimental or investigational treatment: within 20 days after assignment from the Commissioner
- Expedited External Reviews: as expeditiously as your condition requires, but not later than:
 - 24 hours after assignment from the Commissioner when the service being appealed is for Substance - Related and Addictive Disorders or co-occurring mental disorder; and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder.
 - 48 hours or seventy-two hours after we receive the request if any portion of the forty-eight hour period falls on a weekend from our receipt of the appeal after assignment from the Commissioner for all other types of services.

Expedited External Reviews involving an experimental or investigational treatment: as expeditiously as your conditions requires, but not later than one business day after receiving such notice for an external review or one calendar day after receiving such notice for an expedited external review.

Upon completion of the review, the Independent Review Organization will communicate it's decision in writing to you, your authorized representative (if appropriate), the Commissioner and to us. If the decision is to reverse or revise our initial or final adverse determination, we will immediately approve the coverage, subject to the terms and conditions of this Certificate. The decision will be binding.

Benefit/Administrative Appeals

The benefit/administrative appeals process is used after you have received an initial adverse determination concerning a claim for benefits or an administrative issue. Benefit issues include, but are not limited to: denials based on benefit exclusions or limitations and claims payment disputes. Administrative issues would include issues such as access to providers, eligibility or enrollment issues.

Please Note: Benefit and administrative issues do not include determinations concerning the medical necessity of covered services. If we have denied your claims or request for services because we believe

the services are not medically necessary, do not use the process outlined in this section. Please refer to the above section, Utilization Review (UR) Appeals.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Within 3 business days of receipt of your appeal, we will send you a notice informing you of your right to submit to us any additional written material you would like us to consider as part of our review. The notice will also provide the address, telephone number and the name of the Department handling your appeal.

Benefit/administrative appeals must begin by you or your authorized representative within 180 days from receipt of an adverse determination (i.e., an Explanation of Benefits, Denial Notice) or, for other issues, from the date when you became aware of the issue that begin the appeal.

We will provide you or your authorized representative or your provider with our written decision (by mail or electronic means) and the detailed reasons for our decision including clinical rationale (if applicable) and references to any specific plan provisions on which our decision was based within 20 business days of receipt of your appeal. This will be our final position.

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.

Within 3 business days of receipt of your appeal, we will send you a notice informing you of your right to submit to us any additional written material you would like us to consider as part of our review. The notice will also provide the address, telephone number and the name of the department handling your appeal.

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 and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, (other than long-term care contracts under the LTC Partnership Program in Connecticut), 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; other than long-term care contracts under the LTC Partnership Program in Connecticut), 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.

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.

End Stage Renal Disease

When a member has end stage renal disease (ESRD) and she/he has enrolled for Medicare coverage, benefits are coordinated in accordance with the Medicare Secondary Payer Rules.

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.
- Notifying you of when the Policy ends.

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.

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

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

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

Notice

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

Statements by Group or Subscriber

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

- 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 your *Schedule of Benefits*.

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-Oxford 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. We will pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

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

This section is subject to the decisions rendered in Section 6: Questions, Complaints and Appeals, as you always have the right to file a complaint or appeal.

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.

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

Amendments to the Policy

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

Subject to applicable law, we have the right to subrogation and reimbursement. 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 fully return to us 100% of any Benefits you receive for that Sickness or Injury. 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. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying 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.
 - Providing any relevant information requested by us.

- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any 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.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the

Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- 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.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful 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. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- 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.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- 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, 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 this happens, we will explain the problem to you, and you must return the overpayment to us. If the refund is due from you do not return the overpayment to us within 60 days after receiving notification from us, 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. However, we will not initiate overpayment recovery efforts more than 24 months after the original payment was made unless we have a reasonable belief of fraud or intentional misrepresentation.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

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

Section 9: Defined Terms

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

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

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

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

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

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

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

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

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

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

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

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

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).

- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Applied Behavior Analysis - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

Autism Spectrum Disorder - means "autism spectrum disorder" as set forth in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

Behavior Therapy - any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Connecticut Commissioner of Social Services, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with Autism Spectrum Disorder, that are:

- Provided to children less than twenty-one years of age; and
- Provided or supervised by any of the following:
 - a behavior analyst who is certified by the *Behavior Analyst Certification Board*,
 - a licensed Physician, or
 - a licensed psychologist.
 - Behavioral Therapy is considered to be supervised by a behavior analyst, licensed Physician or licensed psychologist when the supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provided for each ten hours of behavioral therapy provided by the supervised provider.
 - Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorders.

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

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

Clinical Peer - will be used to evaluate the clinical appropriateness of an adverse determination and for external review determinations. A clinical peer is a physician or other health care professional who:

- (A) holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
- (B) for an urgent care review concerning
 - A child or adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or a child or adolescent mental disorder, holds (1) a national board certification in child and adolescent psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or child and adolescent mental disorder, as applicable, or
 - An adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or an adult mental disorder, holds (1) a national board certification in psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or adult mental disorders, as applicable.

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

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

Continuity of Care - If you are undergoing an active course of treatment when a provider leaves the network, you may be eligible for Continuity of Care. For purposes of Continuity of Care, the following definitions apply:

Active Course of Treatment:

- A Medically Necessary, ongoing course of treatment for a life-threatening condition; or
- A Medically Necessary, ongoing course of treatment for a serious condition; or
- Medically Necessary care provided during the second or third trimester of pregnancy; or
- A Medically Necessary, ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the covered person's condition or interfere with anticipated outcomes.
- **Life-Threatening Condition:** a disease or condition for which the likelihood of death is probable unless the course of such disease or condition is interrupted.
- **Serious Condition:** a disease or condition that requires complex ongoing care such as chemotherapy, radiation therapy or postoperative visits, which the Covered Person is currently receiving.
- **Treating Network Provider:** a Member's treating health care provider or a facility at which the Member is receiving treatment that is removed from or leaves a health carrier's network.
- If you receive notice from us that your Treating Network Provider is no longer in our Network, you may be able to continue to receive Covered Health Care Services from your former Network Provider on an in-network basis in the following instances:
- You are in your second or third trimester of pregnancy: You may receive Covered Health Care Services through delivery and any post-partum care directly related to the delivery.
- You are undergoing an active course of treatment: We may extend in-network coverage to the earliest of the following:
 - ◆ Termination of the course of treatment by you or your treating provider; or
 - ◆ 90 days after the treating provider is removed from or leaves the network, unless Our Medical Director determines that a longer period is necessary; or
 - ◆ The date that care is successfully transitioned to another network provider; or
 - ◆ The date the benefit limitations under the health benefit plan are met or exceeded; or
 - ◆ The date We determine care is no longer Medically Necessary.
 - ◆ Continuity of Care is available only if the provider agrees to continue to follow Our reimbursement rates, policies and procedures. If the provider so agrees, you will receive these Covered Health Care Services as if they are being provided by a network provider. You will only be responsible for the in-network cost share, which will be applied to the in-network deductible and Out-of-Pocket Limit, if applicable to your plan. Pregnancies that are affected by this provision are automatically covered on an in-network basis.

If the Treating Network Provider was terminated by Us due to quality of care, Continuity of Care is not available.

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

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

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

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

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

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

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

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

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

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the policy anniversary date following the date the child reaches age 26.

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

The Dependent age limit will be specified in your *Schedule of Benefits*, including if your Group has chosen a Dependent age above 26.

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

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

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

Designated Provider - a provider and/or facility that:

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

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

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

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

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

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

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

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

- Placing the 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.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use, except that coverage is provided for a drug which has been prescribed for treatment of certain types of cancer for which the drug has not been approved by the *FDA*, provided the drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following three established reference compendia: (1) *The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital's Pharmacist's American Hospital Formulary Service Drug Information (AHES-DI)*. However, there is no coverage for any drug which the *FDA* has determined to be contraindicated for the specific cancer for which the drug has been prescribed.

2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight. except that Benefits for a procedure, treatment or the use of any drug will not be denied as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase 3 clinical trial.
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.

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

Genetic Testing - 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 - an agency or organization which meets all of the following:

- Is primarily engaged in and is federally certified as a home health agency and is duly licensed (if such licensing is required) by the appropriate licensing authority to provide nursing and other therapeutic services.
- Has their policy established by a professional group associated with the agency or organization, including at least one Physician and at least one registered nurse, to govern the services provided.
- Provides for full-time supervision of such services by a Physician or by an advanced practiced registered nurse.
- Maintains a complete medical record on each patient.
- Has an administrator.

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.

Individual Treatment Plan - a treatment plan prescribed by a Physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

Medically Necessary - health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms 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, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), 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.

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, or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

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. In determining whether health care services are Medically Necessary, we reserve the right to consult a subject matter expert of our choice and apply physician relevant specialty society recommendations.

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.

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 *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service. "Mental or nervous conditions" does not include additional

conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service. "Mental or nervous conditions" does not include additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

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.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* Criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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

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

Out-of-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 - 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, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

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

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

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

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

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

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

1. An *All Payer Model Agreement* if adopted, or
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 if you have Benefits for Outpatient Prescription Drugs, while presented in Rider format, they 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.

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider and a third party vendor. When this program applies, the out-of-Network provider's billed charges will be discounted. Co-insurance and any applicable deductible would still apply to the reduced charge. Our policy provisions or administrative practices may supersede the scheduled rate. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.
- The median amount negotiated with Network providers for the same or similar service.

In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card for assistance with resolving that issue. Shared Savings Program providers are not Network providers and are not credentialed by us.

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

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

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

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

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

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

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *Diagnostic and Statistical Manual of 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.

Surprise Bill - A bill for health care services, other than emergency service or urgent crisis center services, received by an insured for services rendered by an out-of-network health care provider or out-of-network clinical laboratories, where such services were rendered by such out-of-network provider or out-of-network clinical laboratories, at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider or out-of-network clinical laboratories.

A "surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network or out-of-network clinical laboratories.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

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

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

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

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

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

Please note:

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

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Outpatient Prescription Drug Rider

Oxford Health Insurance, Inc.

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 Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *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*.



Junior Harewood
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, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to

dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, by contacting us at www.myuhc.com or the telephone number on your ID card.

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.

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.

Special Programs

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

Maintenance Medication Program

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

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you must meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your *Certificate*, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may

access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist

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

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Section 1: Benefits for Prescription Drug Products

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

Prescription Drugs from a Retail Out-of-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

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

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drugs* section of the *Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
4. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to drugs for the treatment of a disabling or life-threatening chronic disease or cancer that have not been approved by the *Federal Food and Drug Administration* for that indication, if the drug has been prescribed for a Covered Person who has been diagnosed with a disabling or life-threatening chronic disease or cancer, provided the drug is recognized for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed in one of the following established reference compendia: (1) *The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI)*. This exception does not provide coverage for any experimental or investigational drugs or any drug which the *Federal Food and Drug Administration* has determined to be contraindicated for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws, subject to applicable law.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
11. Certain unit dose packaging or repackagers of Prescription Drug Products.

12. Medications used for cosmetic purposes, except for medications prescribed for gender identity reasons as outlined in your *Certificate of Coverage*. These medications require medical necessity review by Us.
13. 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, except that such review and approval of new Prescription Drug Products and/or new dosage forms will not be required for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in a substantially accepted peer-reviewed medical literature. The standard reference compendia are noted above under the Experimental, Investigational or Unproven Services Exclusion.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Certain Prescription Drug Products for tobacco cessation.
16. 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 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 either Tier 2 or Tier 3.)
17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
18. Growth hormone therapy. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
19. 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
20. Certain Prescription Drug Products that have not been prescribed by a Specialist.
21. A Prescription Drug Product that contains marijuana, including medical marijuana unless prescribed as treatment for pain management.
22. A Prescription Drug Product with either:
 - An approved biosimilar.
 - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

 - It is highly similar to a reference product (a biological Prescription Drug Product).
 - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
25. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

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

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

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

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

Infertility - not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

- One year, if you are a female under age 35.
- Six months, if you are a female age 35 or older.

In addition, in order to be eligible for Benefits, you must also:

- Be a female under age 44.
- Have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

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

- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

Out-of-Pocket Drug Limit - the maximum amount you pay for covered Prescription Drug Products every year. The *Outpatient Prescription Drugs* section of the *Schedule of Benefits* will tell you how the Out-of-Pocket Drug Limit applies.

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*.
- 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.

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. The amount you pay for a prescription will be the lesser amount of the drug, you will not have to pay the applicable copayment if the drug cost is less.

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.
- Hypodermic needles or syringes
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
 - glucose meters, including continuous glucose monitors.
 - any medically necessary diabetic supplies.
- Topical dental preparations.

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.

Specialized Formula - A nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products include 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 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.

UnitedHealthcare Rewards Rider

Oxford Health Insurance, Inc.

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 Oxford Health Insurance, Inc. 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 wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

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

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health 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. |
| Active - Fitness | 30 minutes or more of activity as designated by the program or 10,000 or more steps per day | |
| Other Health-Related Actions and/or Activities | One or more actions and/or activities defined by us and aimed at the following: <ul style="list-style-type: none">• Health education;• Improving health; or | |

| | | |
|--|----------------------|--|
| | • Maintaining health | |
|--|----------------------|--|

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

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

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

Rewards

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

Device

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



Junior Harewood
President

Sweat Equity Fitness Reimbursement Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides a description of the Sweat Equity Fitness Reimbursement 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 (Certificate)* in *Section 9: Defined Terms*.

When we use the words "we", "us", and "our" in this document, we are referring to Oxford Health Insurance, Inc.. When we use the words "you" and "your" we are referring to the Subscriber and Spouse and Enrolled Dependents.

Sweat Equity Fitness Reimbursement Program

The purpose of this fitness reimbursement program is to encourage you to take a more active role in managing your health and well-being.

We will provide partial reimbursement for eligible fees associated with certain exercise that promotes cardiovascular wellness as described below.

Exercise activity fees include costs you pay for exercise facility fees, or exercise facility and class membership fees, outdoor bike rentals, organized group exercise classes, individual fitness instruction, organized group physical event, such as a marathon but only if such fees are paid to facilities or organizations which maintain equipment and/or offer programs, which may include certain digital application-based exercise programs, that promote cardiovascular wellness and are available to the general public. You can call us at the telephone number on your ID card for the current list of any eligible digital application-based exercise programs.

Membership in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits, organized group exercise classes, sessions, bike rides or organized group physical events. We will not provide reimbursement for the purchase of equipment, clothing, vitamins or other items or services that may be offered by the facility or organization (e.g., massages, etc.).

In order to be eligible for reimbursement, you must:

- Be an active member of the facility or program, attend organized group classes at the exercise facility or organization, and
- Complete a combined total of 50 visits, organized group classes, sessions, bike rides or organized group physical events in a six-month period.

In order to obtain reimbursement, at the end of the six-month period, you must submit:

- A completed reimbursement form from the facility or program of your visits, sessions, and events. Each time you use the exercise facility, a facility representative must sign and date the reimbursement form; documentation of the visits, such a system-generated, dated accounting of your workout(s).
- A copy of your current facility bill(s), class or program bill which shows the fee paid for your class membership, workout visits, organized group classes, sessions, bike rides or organized group physical events.
- A copy of the brochure or website printout that outlines the services or programs the exercise facility, class, session or event offers.

Once we receive the completed reimbursement form; documentation of the visits and the facility, class, event, or program bill(s), the Subscriber will be reimbursed up to \$200 and each Enrolled Dependent will be reimbursed up to \$100 or the actual cost of the eligible facility, class, program, session, event or membership per six month period, whichever is less. If you are unable to meet a standard related to a health factor for reimbursement under this fitness reimbursement program, you might qualify for an opportunity to earn the same reward by different means. Call us at the number on your identification (ID card, and we will work with you and, if necessary, your Physician, to find another way for you to earn the same reward.

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

Reimbursement must be requested within 120 days of the end of the six-month period. Reimbursement will be issued only after you have completed each six-month period even if 50 visits are completed sooner.



Junior Harewood
President

Real Appeal Rider

Oxford Health Insurance, Inc.

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 13 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.



Junior Harewood
President

Domestic Partner Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides coverage for Domestic Partners.

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 the Certificate of Coverage (*Certificate*) in *Section 9: Defined Terms* and in this Rider below.

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

Coverage for Domestic Partners

The provisions below replace the provision shown in the *Certificate* in order to add coverage for Domestic Partners when they are enrolled as Dependents of Subscribers.

Section 3: When Coverage Begins

The section titled Adding New Dependents in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 (61 days for newborns) of the event.

The section titled Special Enrollment Period in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 (61 days for newborns) days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day 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 9: Defined Terms

The definition of Dependent in the Certificate under Section 9: Defined Terms is replaced with the following:

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*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

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

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the policy anniversary date following the date the child reaches age 26.

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

The following definitions of Domestic Partner and Domestic Partnership are added to the Certificate under Section 9: Defined Terms:

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 and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - They have a single dedicated relationship of at least 6 - 18 months.
 - They have joint ownership of a residence.
 - They have at least two of the following:

- ◆ A joint ownership of an automobile.
- ◆ A joint checking, bank or investment account.
- ◆ A joint credit account.
- ◆ A lease for a residence identifying both partners as tenants.
- ◆ A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

A handwritten signature in cursive script that reads "Jessica Paik".

Jessica Paik
President

Zero Cost Share Medications Addendum

Oxford Health Insurance, Inc.

As described in this addendum, certain Prescription Drug Products as described in the *Outpatient Prescription Drug Rider* and *Schedule of Benefits* are modified as stated below.

Because this addendum 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 (Certificate)* in *Section 9: Defined Terms*, in the *Outpatient Prescription Drug Rider* in *Section 3: Defined Terms*, and in this addendum below.

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

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

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

The following definition is added to *Section 3: Defined Terms* in the *Outpatient Prescription Drug Rider*:

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). 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.

The List of Zero Cost Share Medications includes certain Prescription Drug Products under these drug classes or categories:

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



Junior Harewood
President

Federal Notices



Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or 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. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

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をご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ **ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយគេគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohji' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ:·Αν·μιλάτε·**Ελληνικά·(Greek)**,·υπάρχει·δωρεάν·βοήθεια·στη·γλώσσα·σας·
Παρακαλείστε·να·καλέσετε·1-866-633-2446.

ध्यान·आपो:·જો·તમે·**ગુજરાતી·(Gujarati)**·બોલતા·હો·તો·આપને·ભાષાકીય·મદદરૂપ·સેવા·
વિના·મૂલ્યે·પ્રાપ્ય·છે·

કૃપા·કરી·1-866-633-2446·પર·કોલ·કરો·

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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 60 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 1-866-633-2446 or 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. ET

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

¹For purposes of the Language Assistance Services and 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 you 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 NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2023:

We² are required by law to protect the privacy of your health information. We are also required to send 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.

The terms "information" or "health information" in this notice include any 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, such as www.myuhc.com. 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 make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may collect, use, and disclose health information needed 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. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **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 Sponsors.** 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. In addition, we 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.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or 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.** We may communicate, electronically or via telephone, these 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:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps 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 interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. 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.
- **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.** We may disclose your health information 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.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information 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 and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 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 Health

11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated 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 promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the 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. To find out where to mail your written authorization and how to revoke an 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** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures 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. **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 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 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 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 will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. 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 or have your information sent to a third party. 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. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive 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; and (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, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. 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 exercising 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.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
 PO Box 740815
 Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint 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.

²This Medical Information 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; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; 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.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; 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, 2023

We³ 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.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices 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 ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, 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, 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*.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- o **Online:** UHC_Civil_Rights@uhc.com
- o **Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- o **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

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

- o **Phone:** Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
- o **Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue. SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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をご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្វែវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyanam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánílti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i. T'áá shqódí ninaaltsoos nít'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

Dear Oxford member,

Welcome, and thank you for selecting Oxford Health Plans.

At Oxford, your satisfaction is important to us, and we strive to help make your healthcare experience a positive one. As an Oxford member, you have access to a series of programs and resources to help you along your road to health.

Network access

We have a large network of hospitals and providers located throughout the tristate region.¹ Network doctors, mental health professionals, hospitals, clinics, and laboratories charge discounted rates, which typically save you money. If your plan offers out-of-area coverage, you may also have national network access outside of the Oxford tristate service area through the UnitedHealthcare Choice Plus or Core network, depending on your medical plan.²

Your personal member website

A self-service health plan member website allows you convenient, around-the-clock access to important information about your health benefits, the ability to request a health plan ID card, update your personal information, and more.

Rally[®]

Rally is a digital health and wellness experience built into your health plan member website that provides personalized lifestyle plans you can adopt as you work toward achieving and maintaining good health.

Sweat Equity Program

This wellness program offers you reimbursement toward your physical fitness expenses—up to \$200 two times per year—after meeting the program requirements.³

Cancer support

This program, led by experienced cancer nurses with assistance from a board-certified medical oncologist, a hematologist, and other doctors, as well as social workers, was created to support members who are affected by cancer. Call 1-866-936-6002 for support.

Centers of Excellence

For bariatric surgery and transplants, these providers are identified for meeting our quality assessment criteria and being in good standing with us and national accreditations.

Mental health and substance disorder services support

You have access to a 24/7 substance disorder services treatment help line, as well as a website dedicated to mental health and substance disorder services support. Call the Substance Use Disorder Helpline at 1-855-780-5955 24 hours a day, 7 days a week.

If you have questions about this information or your coverage, or if you want to learn more about available programs and resources, log in to your health plan member website or call Customer Service. The website address and our phone number are shown on your health plan ID card.

Wishing you the best of health,

The Oxford Team

¹ Tristate area includes Connecticut, New Jersey, and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau, and Suffolk). Network access may vary by plan.

² National network may not be available for all groups.

³ Reimbursement is generally limited to the lesser of \$200 (subscriber)/\$100 (covered spouse/partner) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. Refer to your benefits documents or check with your benefits administrator to find out how much you may be reimbursed. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. Oxford does not guarantee availability of programs in all service areas and provider participation may vary. Certain items may be excluded from coverage and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated.

The Centers of Excellence (COE) program providers and medical centers are independent contractors who render care and treatment to health plan members. The COE program does not provide direct health care services or practice medicine, and the COE providers and medical centers are solely responsible for medical judgments and related treatments. The COE program is not liable for any act or omission, including negligence, committed by any independent contracted health care professional or medical center.

UnitedHealthcare and Oxford do not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card 8 a.m. – 6 p.m. ET, Monday – Friday. TTY users can dial 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증

카드에 기재된 무료 회원 전화번호로 문의하십시오.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Administrative services provided by Oxford Health Plans LLC.

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Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to myuhc.com, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to myuhc.com or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.



Oxford Health Plans (CT), Inc.

Large Business Market

KACTOHPLiberty2021_02pdDR1

Schedule of Benefits

Tiered Network Plan

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|--|--------------------------------------|---|
| Plan Deductible Individual Family | \$3,000 per Covered Person. \$3,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family. | | N/A |
| Separate Prescription Drug Deductible Individual | \$250 per member | | N/A |
| Out-of-Pocket Maximum Individual Family (Includes deductibles, copays and coinsurance) | \$6,000 per Covered Person. \$6,000 per Covered Person, not to exceed \$12,000 for all Covered Persons in a family. | | N/A |
| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Provider Office Visits | | | |
| Adult/Pediatric Preventive Visits | N/A | No Cost | N/A |
| Primary Care Provider Office Visit (includes services for illness, injury, follow-up care and consultations) | No Cost | \$25 per visit | N/A |
| Specialists Office Visits | \$40 per visit | \$65 per visit | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|--|--|---|
| Mental Health and Substance Abuse Office Visits | N/A | No Cost | N/A |
| Outpatient Diagnostic Services | | | |
| <p>Advanced Radiology (CT/PET Scan, MRI)</p> <p>For Designated Network Benefits, services must be received from a Designated Diagnostic Provider.</p> <p>Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.</p> | <p>Designated Network</p> <p>N/A</p> | <p>Network</p> <p>Freestanding Facility: \$0 copayment per visit after INET deductible is met</p> <p>Hospital Based: \$0 copayment per visit after INET deductible is met</p> <p>Please refer to your provider directory to identify freestanding facilities and hospital-based facilities.</p> | N/A |
| <p>Laboratory Services</p> <p>Limited to 18 Presumptive Drug Tests per year.</p> <p>Limited to 18 Definitive Drug Tests per year.</p> <p>For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider.</p> <p>Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.</p> | <p>Designated Network</p> <p>\$20 per service</p> | <p>Network</p> <p>50% per service after INET deductible is met</p> | N/A |
| Non-Advanced Radiology (X-ray, Diagnostic) | N/A | \$0 copayment per service after INET deductible is met | N/A |
| Mammography | N/A | No Cost | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|--|---|
| Ultrasound Please refer to the Certificate for further information on this benefit coverage. | | | |
| Prescription Drugs – Retail Pharmacy (31 day supply per prescription) | | | |
| Tier 1 | N/A | \$5 copayment per prescription | N/A |
| Tier 2 | N/A | \$50 copayment per prescription | N/A |
| Tier 3 | N/A | 30% coinsurance up to \$500 maximum per prescription after RX drug deductible is met | N/A |
| Tier 4 | N/A | 50% coinsurance up to \$750 maximum per prescription after RX drug deductible is met | N/A |
| Prescription Drugs – Mail Order Pharmacy (90 day supply per prescription) | | | |
| Tier 1 | N/A | \$10 copayment per prescription | N/A |
| Tier 2 | N/A | \$100 copayment per prescription | N/A |
| Tier 3 | N/A | 30% coinsurance up to \$1,000 maximum per prescription after RX drug deductible is met | N/A |
| Tier 4 | N/A | 50% coinsurance up to \$1,500 maximum per prescription after RX drug deductible is met | N/A |
| Outpatient Rehabilitative and Habilitative Services | | | |
| Speech Therapy 60 visits per year limit combined for Rehabilitative (physical, | N/A | \$30 per visit | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|---|--|---|
| speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, physical and occupational therapies). | | | |
| Physical and Occupational Therapy 60 visits per year limit combined for Rehabilitative (physical, speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, physical and occupational therapies). | N/A | \$30 per visit | N/A |
| Other Services | | | |
| Chiropractic Services (up to 30 visits per year for Rehabilitative chiropractic services, separate 30 visits per year limit for Habilitative chiropractic services.) | \$40 per visit | \$65 per visit | N/A |
| Diabetic Equipment and Supplies For medically necessary covered insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$25 for an individual prescription of up to a 30-day supply. For medically necessary covered noninsulin drugs the total amount of Deductible, Co-payments or Co- | N/A | Supplies obtained from your Physician are subject to the applicable Physician Cost Share. Supplies obtained through the pharmacy are subject to the applicable Pharmacy cost share based on Tier. | N/A |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|---|--|---|
| <p>insurance shall not exceed \$25 or an individual prescription of up to a 30-day supply.</p> <p>For medically necessary covered diabetes devices and diabetic ketoacidosis devices the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$100 for an individual prescription of up to a 30-day supply.</p> | | | |
| Durable Medical Equipment (DME) | N/A | \$0 copayment per item after INET deductible is met | N/A |
| Home Health Care Services (up to 100 visits per year) | N/A | No Cost | N/A |
| Outpatient Services (in a hospital or ambulatory facility) | N/A | \$0 copayment per service after INET deductible is met | N/A |
| Prosthetic Services | N/A | \$0 copayment per item after INET deductible is met | N/A |
| Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all IP settings. (skilled nursing facility stay and inpatient rehabilitation is limited to 90 days per year combined) | N/A | \$0 copayment per admission after INET deductible is met | N/A |
| Emergency and Urgent Care | | | |

| Benefit | Designated In-Network (INET) Member Pays | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|--|---|
| <p>Ambulance Services</p> <p>Emergency Ambulance</p> <p>Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p> <p>Non-Emergency Ambulance</p> <p>Ground or Air Ambulance, as we determine appropriate.</p> <p>Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p> | N/A | No Cost | Same as INET |
| Emergency Room | N/A | \$300 per visit after INET deductible is met | Same as INET |
| Urgent Care Centers | N/A | \$75 per visit | N/A |

ADDITIONAL INFORMATION: MEDICAL SERVICES

What Will You Pay for Covered Health Care Services?

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Emergency Health Care Services – Outpatient

If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, 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.

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. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.

Benefit Limitations

The benefits listed below have the following limitations:

Outpatient Rehabilitation and Habilitative Services:

Post-Cochlear Implant Aural Therapy is limited to 60 visits per year for Rehabilitative post-cochlear implant aural therapy and a separate 60 visits per year limit for Habilitative.

Cognitive Therapy is limited to 60 visits per year for Rehabilitative cognitive therapy and a separate 60 visits per year for Habilitative.

Hearing aids

Hearing Aids will be covered once every 24 months.

The above limit does not apply to over-the-counter hearing aids. For over-the-counter hearing aids, Benefits are limited to \$1,000 every year. Benefits are further limited to a single purchase every year.

Fertility Preservation for Iatrogenic Infertility:

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.

Preimplantation Genetic Testing (PGT) and Related Services:

Benefit limits for related services will 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.

This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider*.

Accessing Benefits

You can choose to receive

Designated Network Benefits or Network Benefits.

Designated Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Care Services as identified in the *Schedule of Benefits* table above.

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

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 below

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?

In general health care terminology, prior authorization may also be referred to as precertification. We require prior authorization for certain Covered Health Care Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

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.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply.

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.

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) 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.

Allowed Amount

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

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***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*.

For Designated Network Benefits and Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and 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.

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 Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

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

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The provider may bill us directly and we will reimburse the provider the greatest of the following amounts:
- The amount we would pay for such services if rendered by an in-network health care provider;
- The usual, customary and reasonable rate for such services; or
- The amount Medicare would reimburse for such services.

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 will be covered the same as in-network.

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

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. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

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

If you are diagnosed with a condition or disease that requires specialty care and either we do not have a Network provider with the required specialty training or if access to a Network provider would require unreasonable travel or delay, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, you may contact us at the telephone number on your ID card, or your Network Physician can notify us. If we confirm that care is not available from a Network provider due to the reasons above, we will work with you and/or your Network Physician to coordinate care through an out-of-Network provider. If your care is coordinated through an out-of-Network provider, Covered Health Care Services will be paid as Network Benefits.

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.

Dependent Age Limit

The Dependent age limit is 26. Coverage ends upon the Policy's anniversary date.

II. ADDITIONAL INFORMATION: OUTPATIENT PRESCRIPTION DRUGS

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Co-payments 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, however this does not apply to emergency contraceptives.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may

change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment 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.

Prescription Drug Tiers

Prescription Drug Products are categorized into cost tiers. Tier one contains lower cost generic drugs. Tier 2 contains preferred lower cost brand drugs. Tier 3 typically contains non-preferred brand drugs. Tier 4 typically contains higher cost brand drugs.

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.

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.

Prescription Drug Products which require prior notification are listed below.

Prescription Drug Products which require Notification: Absorica, Abstral, Actemra (subcutaneous formulation), Actimmune, Actiq, Adcirca, Adderall, Adderall XR, Adempas, Afinitor, Alecensa, Amitiza, Amnesteem, Ampyra, Aptiom, Arcalyst, Atralin, Aubagio, Avita, Avodart, Avonex, Banzel, Berinert, Betaseron, Bethkis, Bosulif, Brilinta, Bunavail, Caprelsa, Cayston, Cerdelga, Cholam, Cimzia, Cinryze, Claravis, Cometriq Compounds and Bulk Powders, Concerta, Copaxone, Cosentyx, Cotellic, Crinone, Cystaran, Daklinza, Daliresp, Daytrana, Desoxyn, Dexedreine, Dextrostat, Differin, Egrifta, Elidel, Eligard, Elocatate, Enbrel, Endometrin, Entresto, Epanova, Erivedge, Esbriet, Evekeo, Exjade, Extavia, Fabior, Farydak, Fentanyl citrate compounds, Fentora, Ferriprox, Firazyr, First Progesterone, Focalin, Focalin XR, Forteo, Fulyzaq, Fycompa, Gattex, Genotropin (excluded), Gilenya, Gilotrif, Gleevec, Grastek, H.P. Acthar, Harvoni, Hettlioz, Humatrope (excluded), Humira, Hycamtin, Ibrance, Iclusig, Imbruvica, Increlex, Infergen, Inlyta, Intron A, Iressa, Jadenu, Jakafi, Jublia, Juxtapid, Kalydeco, Kerydin, Keveyis, Kineret, Kitabis Pak, Korlym, Kuvan, Kynamro, Lazanda, Lenvima, Letairis, Linzess, Lonsurf, Lotronex, Lovaza, Lynparza, Mekinist, Metadate, Metadate CD, Metadate ER, Movantik, Multaq, Myalept, Myorisan, Natpara, Nexavar, Ninlaro, NordiFlex, Norditropin (excluded), Nutropin, Nutropin AQ, Nutropin AQ NuSpin, Nuvigil, Odomzo, OFEV, Olysio, Omnitrope (excluded), Omtryg, Onfi, Opsumit, Oralair, Orenzia (subcutaneous formulation), Orenitram, Orkambi, Otezla, Peg-Intron/Pegasys, Plegridy, Pomalyst, Potiga, Praluent, ProCentra, Procysbi, Promacta, Protopic, Porvigil, Pulmozyme, Quillivant XR, Ragwitek, Ravicti, Rebif, Rebif Rebidose, Rectiv, Regranex, Repatha, Restasis,

Retin-A, Retin-A Micro, Revatio, Revlimid, Ritalin, Ritalin LA, Ritalin SR, Ruconest, Saizen, Sandostatin/octreotide, Selzentry, Serostim, Signifor, Simponi, Sirturo, Solaraze, Sotret, Sovaldi, Sprycel, Stelara, Stivarga, Strensiq, Suboxone/Subutex, Subsys, Sutent, Sylatron, Syprine, Tafinlar, Tagrisso, Tarceva, Targretin, Tassigna, Tazorac, Tecfidera, Technivie, Temodar, Thalomid, TOBI, TOBI Podhaler, Tracleer, Tretinoin cream, Tretinoin gel, Tretin-X, Tykerb, Tyvaso, Upravi, Valchlor, Vascepa, Vecamyl, Ventavis, Victrelis, Viekira Pak, Vimpat, Votrient, Vyvanse, Xalkori, Xeljanz, Xtandi, Xyrem, Zelboraf, Zenatane, Zenzedi, Zomacton, Zontivity, Zorbitive, Zubsolv, Zydelig, Zykadia, Zytiga.

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 or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service, however a member has the right to file an appeal if a prescription drug product is determined not to be a covered health care 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 the *Outpatient Prescription Drug Rider* are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

This step therapy process will not require you to use an alternative brand name prescription drug or over-the-counter drug prior to using a brand name prescription drug that has been prescribed by a licensed physician for pain treatment. We may require you to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug. Step therapy is not required for a prescribed drug for cancer treatment for a Covered Person who has been diagnosed with state IV metastatic cancer when the prescribed drug is in compliance with approved federal Food and Drug Administration indications.

Prescription Drug Products subject to step therapy requirements: H.P. Acthar, Cystagon, Depakote, Depakote ER, Stavzor, Keppra, Keppra XR, Lamictal, Lamictal ODT, Lamictal XR, Lamotrigine ER, Lamotrigine ODT, Neurontin, Tomamax, Trileptal, Oxtellar XR, Qudexy XR, Zonegran, Trokendi XR,

Cialis (tadalafil) 2.5 & 5 mg, Bosulif, Sprycel, Xtandi, Amitiza, Brintellix, Fetzima, Inokana, Jardiance, Farxiga, Januvia, Janumet, Janument XR, Xigduo XR, Glyxambi, Trulicity, Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog Mix 70/30, Apidra, Apidra SoloStar, Afrezza, Oxistat, Jublia, Kerydin, Uloric, Nexium suspension (esomeprazole), Prevacid SoluTab (lansoprazole), Olysio, Sovaldi, Victrelis, Viekira Pak, Peg-Intron, Repatha, Lescol XL, Livalo, Stribild, Genvoya, Bravelle, Follistim AQ, Resulti, Rasuvo, Otrexup, Aubagio, Gilenya, Rebif, Rebif Rebidose, Extavia, Rescula, Travoprost (generic Travatan), Zioptan (tafluprost), Butrans, Embeda, Avinza, Exalgo, Hysingla, Kadian, MS Contin (Brand Only), Oxycontin, Oxymorphone hcl ER (generic Opana ER), Pancreaze, Pertzeye, Ultresa, Viokace, Otezla, Xeljanz, Actemra, Orencia, Enbrel, Cosentyx, Lyrica, Cordran SP cream (flurandrenolide).05% cream), Cordran Lotion (flurandrenolide 0.05% lotion, Desonate (desonide 0.05% gel), Cloderm cream (clocortolone pivalate 0.1% cream), Halog cream (halcinonide 0.1%), Halog ointment (halcinonide 0.1% ointment), Soolantra, Belsomra, Rozerem, Zolpmist, Zovirax ointment.

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

What Do You Pay?

You are responsible for paying the Annual Drug Deductible.

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.

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

Benefits for Prescription Drug Products on the List of Zero Cost Share Medications are not subject to payment of the Annual Drug Deductible unless required by state or federal law.

Benefits for insulin or diabetic supplies are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Annual Deductible or Out-of-Pocket Limit.

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

- Ancillary Charges.
- 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.

Certificate of Coverage

Oxford Health Plans (CT), Inc.

This policy is intended to be federally tax qualified. Approval by the Insurance Department does not guarantee tax qualification and members and enrollees are encouraged to seek the counsel of a tax advisor.

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between Oxford Health Plans (CT), Inc. 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* if purchased by the Group.
- 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 Connecticut. The Policy is subject to the laws of the state of Connecticut and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Connecticut 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 Oxford Health Plans (CT), Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 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

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

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 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.

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. 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.

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 or are state/federally mandated:

- 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 requirements specified in the Policy.

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

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

1. Abortion Services

Benefits include services for a therapeutic abortion, that is an abortion recommended by a Provider performed to save the life or health of the mother, or as a result of incest or rape. The plan will also cover elective abortions.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the 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.

3. 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*.

4. 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.
- Disabling or life-threatening chronic disease.

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - 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 patient care costs are subject to the terms, conditions, restrictions, exclusions and limitations of this Policy. If treatment is not available at an in-network facility, coverage may be provided at an Out-of-network hospital at no greater cost than if such treatment was available in-network.

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 disabling or 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 disabling or life-threatening diseases or conditions. 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 disabling or life-threatening diseases or conditions, 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 disabling or life-threatening diseases or conditions. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)* .)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

5. Dental Services - Accident Only

Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair (not replacement) of sound natural teeth when both of the following are true:

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

Please note that dental damage that happens as a result of normal activities of daily living (such as biting or chewing) or intentional misuse 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 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 include the following:

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

6. Diabetes Services

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

Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes.

Coverage includes:

- Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to:
- Counseling in nutrition.
- The use of equipment and supplies
- Training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes.
- Training and education, up to four hours, because of the development of new techniques and treatments.

Diabetic Self-Management Items

Insulin pumps, supplies and medications for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps which are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment.
- Insulin.
- Oral agents such as glucose tablets and gels.
- Glucagon for use with injection to increase blood glucose concentration.
- Blood glucose meters including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

If your Benefit plan includes an *Outpatient Prescription Drug Rider*, Benefits for diabetic medications and supplies may be provided as described in the Outpatient Prescription Drugs section of the *Schedule of Benefits*.

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 *Devices, Appliances, Medical Equipment and Prosthetics*.

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

8. Emergency Health Care Services - Outpatient

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

Coverage includes Emergency Health Care Services due to accidental ingestion or consumption of a controlled drug. A "controlled drug" is a substance such as cocaine, morphine, hallucinogens, etc. It does not include alcohol, nicotine or caffeine.

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). This also includes coverage for isolation care and emergency services provided by the state's mobile field hospital.

Benefits do not include follow-up care provided in a Hospital Emergency room.

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions.

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.

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

12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed 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.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

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.

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

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

14. Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, or advanced practice registered nurse (APRN), or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available for:

- Part-time intermittent home nursing care by or supervised by a registered professional nurse.
- Part-time or intermittent home health aide services.
- Home Health Agency services include physical, occupational or speech therapy.
- Benefits are available for the following items to the extent that they would have been available if the Covered Person were confined to a Hospital:
- Medical supplies.
- Drugs and medicine.
- Laboratory services.
- Medical social services, including but not limited to those provided to or for the benefit of a Covered Person diagnosed by a Physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live. Medical social services are services, rendered under the direction of a Physician or an advanced practice registered nurse, by a qualified social worker. These services include, but are not limited to:
 - Assessment of the social, psychological and family problems related to or arising out of such Covered Person's illness and treatment.
 - Appropriate action and utilization of community resources to assist in resolving such problems.
 - Participation in the development of the overall plan of treatment for such Covered Person.
 - Continued care and treatment by an APRN and plan established and approved in writing by an APRN.

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 including radiologists, anesthesiologists, pathologists and Emergency room Physicians.

We will pay Benefits for an Inpatient Stay of at least 48 hours following a mastectomy or lymph node dissection. We will pay Benefits for a longer Inpatient Stay if it is recommended by the Physician after conferring with the patient.

17. Infertility Services

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

For the purpose of this benefit, infertility is defined as the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

Coverage must be provided for the expense for the diagnosis and treatment of infertility, including but not limited to:

- Ovulation induction.
- Intrauterine insemination.
- In-vitro fertilization.
- Uterine embryo lavage.
- Embryo transfer.
- Gamete intra-fallopian transfer (GIFT).
- Zygote intra-fallopian transfer (ZIFT).
- Low tubal ovum transfer.

Benefits for infertility include but are not limited to the following:

- Ovulation induction is limited to a maximum benefit of four cycles;
- Intrauterine insemination is limited to a maximum benefit of three cycles;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to a maximum of two cycles, with no more than two embryo implantations per cycle;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful;

Covered Health Care Services must be performed at facilities that conform to the standards of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

18. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Additional screenings and services to monitor for breast cancer and other gynecological cancers may be considered preventive care services under state law. When applicable, They are covered with no Copayments or Coinsurance, however your Deductible may apply.
- These may be available to you, if you are believed to be at an increased risk due to:
- A family history, or

- A prior personal history of breast, ovarian, or certain related cancers, or
- If the treatment of a childhood cancer has increased your risk of breast cancer, or
- A positive genetic test for gene variants that increase your risk to certain cancers, or
- Other indications as determined by the insured's physician, advanced practice registered nurse, physician assistant, certified nurse midwife or other medical provider.
- Requirements for each screening or service may vary and may be subject to Medical Necessity review.
- Diagnostic and screenings services may include, but may not be limited to:
- Mammograms, including mammograms provided by Breast Tomosynthesis.
- Comprehensive Ultrasound screening of an entire breast or breasts [if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
- Magnetic Resonance Imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.
- Mastectomies intended to prevent disease (prophylactic mastectomy).
- Genetic Testing.
- Routine screening procedures and surveillance tests for ovarian cancer.
- 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.*)
- Prostate Specific Antigen (PSA) tests to screen for prostate cancer for men who are symptomatic or whose biological father or brother has been diagnosed with prostate cancer and for all men fifty years of age or older. The treatment of prostate cancer is covered provided such treatment is medically necessary and in accordance with guidelines established by the *National Comprehensive Cancer Network*, the *American Cancer Society* or the *American Society of Clinical Oncology*.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

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*.

19. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services including radiologists, anesthesiologists and pathologists.

20. Medical Supplies

Benefits for medical supplies for Covered Health Care Services required for the treatment of Sickness or Injury. This includes maintenance supplies, such as ostomy supplies.

Benefits for diabetic supplies are described under *Diabetes Services*. Benefits for supplies associated with DME are described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

21. Mental Health Care Services

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

Benefits include the following levels of care:

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.
- Intensive, home-based services designed to address specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.
- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities.
- Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician, or advanced practice registered nurse (APRN) and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:

- The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, or advanced practice registered nurse (APRN), psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
- Extended day treatment programs.
 - Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities.
 - Observation beds in acute hospital settings.
 - Psychological and neuropsychological testing conducted by an appropriately licensed health care provider.
 - Trauma screening conducted by a licensed behavioral health professional.
 - Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional.
 - Substance use screening conducted by a licensed behavioral health professional.

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 include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA).

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

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

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

22. Oral Surgery

The following limited dental and oral surgical procedures in either an inpatient or outpatient setting:

- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Removal of cysts related to teeth is not covered.
- Surgical and nonsurgical medical procedures for temporomandibular joint (TMJ) disorders and orthognathic surgery.

23. Orthoptic Exercises and Corneal Topographic Procedures

Orthoptic exercises for the treatment of the following conditions:

- Amblyopia for Covered Persons up to age 19. Treatment includes patching and penalization therapies.
- Convergence insufficiency.

Corneal topographic procedures for the treatment of certain conditions.

24. Ostomy Supplies

Benefits for Medically Necessary appliances and supplies relating to an ostomy include, but are not limited to, the following:

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

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

25. Pharmaceutical Products – Outpatient

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

Benefits are provided for Pharmaceutical Products which, due to their 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 may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card. Step therapy does not apply to Pain Management services and cancer treatment for a member who has been diagnosed with stage IV metastatic cancer provided a prescribed drug is in compliance with approved federal Food and Drug Administration indications.

Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Co-payment and/or Co-insurance, you may receive Pharmaceutical Products 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 order or refill and/or the amount dispensed per month's supply.

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

Certain Specialty Pharmaceutical Products are eligible for coupons or offers 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 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 Specialty Pharmaceutical Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Schedule of Benefits*.

The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.

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.

26. 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 allergy testing and treatment, including routine allergy injections.

Immunization coverage and 20 minute immunization consultation between Member and the Physician.

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

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

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

27. Pregnancy - Maternity Services

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

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

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

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If discharge occurs earlier than these timeframes, we will pay Benefits for a follow-up visit within 48 hours of discharge and an additional follow-up visit within seven days of discharge.

Follow-up services will include, but not limited to, the following:

- Physical assessment of the newborn.
- Parent education.
- Assistance and training in breast or bottle feeding, which is covered as long as Medically Necessary and is not limited to the follow-up visit within 48 hours of discharge or the additional follow-up visit within 7 days of discharge.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests.

Follow-up services must be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations. Follow-up services must be provided by a qualified health care personnel trained in post-partum maternal and newborn pediatric care.

28. 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).

29. 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*.
- 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. 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.

30. 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, Medical Equipment and Prosthetics*.

31. Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implementation, which removal is determined to be Medically Necessary by the Physician.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, 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.

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

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

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

Benefits are not available for maintenance/preventive treatment.

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

33. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

Included under this section is coverage for colorectal cancer screenings, including, but not limited to annual fecal occult blood test, colonoscopy and flexible sigmoidoscopy/radiologic imaging in accordance with the recommendations established by the *American Cancer Society*. There is no cost share when more than 1 colonoscopy is ordered in a policy year.

34. Second and Third Opinions

Second and third opinions requested by you or by us.

At your request:

- If you disagree with a Network provider's recommended course of treatment, you may request that another provider render a second opinion.
- If the first and second opinions do not agree, we will designate a Network provider to render a third opinion at no cost to you.
- After reviewing the third opinion, we will cover the Covered Health Care Services supported by a majority of the providers reviewing your case.
- If the first opinion concerns a diagnosis of cancer (either negative or positive) or treatment for cancer, you may obtain a second opinion from an out-of-Network provider on a Network basis.

At our request:

- We reserve the right to require a second opinion for any surgical procedure.
- If a second surgical opinion is required, we will refer you to a Network provider for the second opinion at no cost to you.
- In the event that the first and second surgical opinions differ, a third opinion will be required. We will designate another Network provider for a third opinion at no cost to you.
- The third opinion will determine whether the procedure will be covered. The providers who render the second or third opinion are not eligible to perform the procedure.

35. 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 including radiologists, anesthesiologists and pathologists.

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.

36. Spine and Joint Surgeries

Benefits for certain inpatient and outpatient spine and joint surgeries which are ordered by a Physician. Spine and joint surgical procedures include the following:

- Spine fusion and disc surgery.
- Total joint replacement and joint revision surgeries.
- Scopic procedures for joints.

37. Substance-Related and Addictive Disorders Services

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

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.
- Intensive, home-based services designed to address specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.

- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities. Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:
 - The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
 - Extended day treatment programs.
 - Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities.
 - Observation beds in acute hospital settings.
 - Psychological and neuropsychological testing conducted by an appropriately licensed health care provider.
 - Trauma screening conducted by a licensed behavioral health professional.
 - Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional.
 - Substance use screening conducted by a licensed behavioral health professional.

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

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

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

38. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

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

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.

- Hysteroscopy.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Sterilization. Note: Sterilization for women is not subject to cost share.
- Physician services including radiologists, anesthesiologists and pathologists.
- Please refer to our provider directory located on our website at www.myuhc.com for assistance with identifying the different types of facilities.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

39. Termination of Pregnancy

Therapeutic abortions and abortions in the case of rape, incest or fetal malformation. Elective abortions are covered. Benefits are limited as stated in the *Schedule of Benefits*.

40. Telehealth Services

Telehealth services are covered when services are received for the diagnosis, prevention, treatment, cure or relief of a physical or mental health conditions, illness, injury or disease. These services are covered to the same extent that the same services would be covered if received during a face to face consultation. The cost share for Telehealth services will be based on the type of provider who rendered the services (Primary Care Physician, Specialist, registered nurse or advanced practice registered nurse), as outlined in your Summary of Benefits. If these services are received from a network Telehealth provider, they will be covered at the network level of benefits, and if received from an Out-of-Network provider, they will be covered at the Out-of-Network level of benefits.

Physicians and APRNs to certify a qualifying patient's use of medical marijuana and provide follow -up care via telehealth.

For purposes of this Benefit, "Telehealth" means the mode of delivering health care or other health care services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a covered member's physical and mental health and includes:

- Interaction between the patient at an originating site and the Telehealth provider at a distant site, and
 - Synchronous interactions, asynchronous store and forward transfers or remote monitoring.
- Telehealth does not include the use of facsimile, texting or electronic mail.

41. Temporomandibular Joint Services

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

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

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

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

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

Non-surgical treatment including, but not limited to, appliances, behavior modification, physiotherapy and prosthodontic therapy is not covered.

42. Therapeutic Treatments - Outpatient

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

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

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 including anesthesiologists, pathologists and radiologists.
- Sleep studies.

43. Transplantation Services

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

Examples of transplants for which Benefits are available include:

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

Donor costs 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.

Human leukocyte antigen testing or histocompatibility locus antigen testing for A, B and DR antigens (testing to determine the compatibility for bone marrow transplants). The bone marrow testing must be performed at a facility certified under the federal Clinical Laboratory Improvement Act and accredited by the American Society for Histocompatibility and Immunogenetics. Enrollees must register for the National Marrow Donor Program when being tested.

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

- Transportation, Lodging and Meal Expenses for Transplants
- Expenses for transplantation, lodging, and meals for the transplant recipient and his or her companion are reimbursable per transplant episode.
- A “transplant episode” is the time from the initial evaluation for the transplant until 90 days after the recipient is discharged from the transplant facility or until the recipient is cleared to return home, whichever is sooner.
- The transplant facility must be more than 300 miles from the transplant recipient’s home for this reimbursement to apply.
- Transportation costs incurred for travel to and from the transplant facility for the transplant recipient and one other individual accompanying the recipient are covered.
- If air transportation is chosen, coverage includes round trip transportation for the transplant recipient and one other individual accompanying the recipient up to two round trips per person.
- If travel occurs via automobile, mileage will be reimbursed based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was undertaken for a maximum of one round trip from the transplant recipient’s home to the transplant facility.
- Transportation, lodging and meal receipts must be submitted to us at the appropriate address listed in the information you receive from us when authorizing this reimbursement.
- There is no coverage for the following expenses:
 - Any expenses for anyone other than the transplant recipient and the designated traveling companion.
 - Any expenses other than the transportation, lodging and meals described in this provision.
 - Local transportation costs while at the transplant facility.
 - Rental car costs.

44. 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*.

45. Virtual Care Services

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

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

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs.

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

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

46. Wigs

Wigs and other scalp hair prosthesis for a Covered Person who suffers hair loss as a result of chemotherapy when prescribed by a licensed oncologist.

Additional Benefits Required By Connecticut Law

47. Craniofacial Disorders

Benefits for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Covered Persons eighteen years of age or younger when prescribed by a craniofacial team recognized by the *American Cleft Palate Craniofacial Association*. This does not provide coverage for cosmetic surgery.

48. Dental Services *

Surgery, general anesthesia, nursing and associated Hospital or Alternative Facility services provided in conjunction with inpatient, outpatient or one-day dental services when the dentist or oral surgeon and the Physician determine that the services are Medically Necessary for the treatment of either of the following types of patient:

- A person who is determined by a dentist, in conjunction with a Physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- A person who has a developmental disability, as determined by a Physician who specializes in primary care that places the person at serious risk.

49. Developmental Needs of Children & Youth with Cancer

- Neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in children due to chemotherapy or radiation treatment.

50. Early Intervention Services

- Coverage for early intervention services provided as part of an individualized family services plan as defined by Connecticut law for a child from birth until the child's third birthday.
- Turns three years of age on or after May first and not later than the first day of the next school year commencing July first.
- Early intervention services are not subject to co-insurance, co-payments, deductibles or other out-of-pocket expenses, regardless of whether the provider is a Network or Out-of-Network provider.

51. Lyme Disease Services

Coverage for Lyme disease treatment, including but not limited to up to 30 days of intravenous antibiotic therapy and/or sixty days of oral antibiotic therapy and further treatment will be provided if recommended.

52. Medical Foods

Coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the treatment of inherited metabolic diseases and are administered under the direction of a Physician.

In addition, coverage must be provided for specialized formulas when they are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician.

Inherited metabolic diseases - a disease for which newborn screening is required under section 19a-55 of the general statutes of Connecticut and cystic fibrosis.

Amino acid modified preparation - a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Specialized formula - a nutritional formula for children up to the age of twelve years of age that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

53. Nutritional Counseling

Nutritional Counseling is a Covered Health Care Service for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity. In addition, the services must be prescribed by a licensed health care professional and provided by a certified, registered or licensed health care professional in a physician's office or outpatient facility.

54. Pain Management

Covered Health Care Services received by a pain management specialist for pain treatment which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

55. Wound Care Supplies

Wound care supplies for the treatment of epidermolysis bullosa when administered under the direction of a Physician. Epidermolysis bullosa is a rare inherited genetic disorder caused by a mutation in the keratin gene. The disorder is characterized by the presence of extremely fragile skin and recurrent blister formation, resulting from minor mechanical friction or trauma. The resulting wounds require continuous treatment.

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. This exclusion does not apply to acupressure and acupuncture services for which Benefits are available as described under *Pain Management* in *Section 1: Covered Health Care Services*.
2. Aromatherapy.
3. Hypnotism.
4. Rolfing.
5. Wilderness, adventure, camping, outdoor, or other similar programs.
6. 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). This exclusion does not apply to services for which Benefits are provided as described under in *Section 1: Covered Health Care Services*.

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

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Removal of teeth (including wisdom teeth).
- 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*.

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.
6. Removal of cysts related to teeth.

C. Devices, Appliances, Medical Equipment 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.
 8. Powered and non-powered exoskeleton devices.
 9. 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*.
 10. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
 11. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to medications covered under *Section 1: Covered Health Care Services*.
2. Self-administered or self-infused medications. This exclusion does not apply to medications covered under *Diabetes Services* in *Section 1: Covered Health Care Services*. 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.
3. Over-the-counter drugs and treatments, unless Medically Necessary.
4. Growth hormone therapy.
5. 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*. However, you have a life-threatening Sickness or condition or medically necessary reason to cover a newly approved FDA medication, the provider could request coverage of the new drug and a clinical review would be provided.
6. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year, unless medically necessary.
7. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year, unless medically necessary.
8. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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

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. Mental Health Care Services

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

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

I. 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.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - 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, escalators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers or water purifiers.
 - Jacuzzis.
 - Mattresses or waterbeds.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Safety equipment.

- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Swimming pools.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Sclerotherapy treatment of veins.
 - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 The exception to this is the removal of a breast implant which was implanted on or prior to July 1, 1994, without regard to the purpose of such implantation.
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 control. All services, supplies, programs and surgical procedures for the purpose of weight control, except surgical procedures that are Medically Necessary for the treatment of morbid obesity.
6. Wigs, except as required for hair loss due to chemotherapy as described in *Section 1: Covered Health Care Services*.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
8. Biofeedback, except as required for treatment of Urinary Incontinence.
9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; and dental restorations. Medically Necessary TMJ services for surgical medical and dental should be covered.
10. Non-surgical treatment of obesity.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
13. Intracellular micronutrient testing.
14. Cellular and Gene Therapy services not received from a Designated Provider.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal 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.
4. No-show charges. If a provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

N. Reproduction

1. The following infertility treatment-related services:

- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, testicular tissue, and ovarian tissue, unless harvesting eggs for surrogate is a covered expense if harvested from the member.
 - Donor services.
2. The following services related to a Gestational Carrier or Surrogate:
- All costs related to reproductive techniques including:
 - ◆ Assisted Reproductive Technology (ART).
 - ◆ Artificial insemination.
 - ◆ Intrauterine insemination.
 - ◆ Obtaining and transferring embryo(s).
 - ◆ Preimplantation Genetic Testing (PGT) and related services.

The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care 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. The reversal of voluntary sterilization.
5. Elective fertility preservation.
6. In vitro fertilization that is not used as an Assisted Reproductive Technology for the treatment of infertility. 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*.

O. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Except as otherwise provided under Conn. Gen. Stat. Section 38a – 527, health care services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements.

Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

P. Substance-Related and Addictive Disorders Services

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

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Q. Transplants

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

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other 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* or 2) transportation, lodging and meal expense for which Benefits are provided as described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain, unless such treatment is Medically Necessary and has been ordered by a pain management specialist.
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.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
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. 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.
5. 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.

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

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.

- Described as a Covered Health Care Service in this Certificate under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
 3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
 7. Follow-up care provided in a Hospital Emergency room.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Blood, blood plasma, blood derivatives and synthetic blood. This exclusion does not apply to services that are covered in *Section 1: Covered Health Care Services*. Apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not covered.
 10. Routine harvesting and storage of stem cells from newborn cord blood.
 11. Autopsy.
 12. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
 13. Services or supplies that have been fraudulently obtained.
 14. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

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.

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live or work within the Service Area.

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.

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

- Birth for the first 61 days even when no dependent coverage is purchased.
- Legal adoption.
- Placement for adoption.
- Marriage or Civil Union.
- 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 (61 days for newborns) of the event.

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

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 (61 days for newborns) 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. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health 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). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

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

If the Group terminates you for any reason other than a layoff or relocation or closing of a covered establishment, or if you voluntarily leave your place of employment, the Group may decide to not pay the premium for you and your Enrolled Dependents after the date of termination. If the Group makes this election, the Group must:

- Notify us within 72 hours of the termination of your employment so that we may process the request; and
- Notify you of the termination of health care coverage
- When the Group has exercised this election and has provided the required notices, your coverage will terminate three calendar days after termination of employment. It is the Group's responsibility to remit to you your portion of the credited premium.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **The Subscriber No Longer Lives or Works within the Service Area**

Your coverage ends on the date or the last day of the calendar month in which the Subscriber no longer lives or works in the Service Area. Coverage will end on the date of that move, even if the Subscriber does not notify us. The Subscriber or the Group must notify us if the Subscriber moves from the Service Area. The Group can provide you with specific information on which of these dates apply.

Dependent coverage will end on the policy anniversary date after the Dependent reaches age 26.

- **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." The Group can provide you with specific information on which of these dates apply.

- **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. The Group can provide you with specific information on which of these dates apply.

- **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. The Group can provide you with specific information on which of these dates apply.

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

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 31 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.

During the first two years the Policy is in effect, 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.

Notice of Termination

The Group must furnish each Subscriber notice of the termination of this Policy. The notice will be mailed or delivered to the Subscriber not less than fifteen days preceding the effective date of the termination. The notice is not required if the Group replaces this Policy with another group health insurance policy without interruption of coverage. If the Group fails to furnish the notice, the Group will be liable for benefits to the same extent as we would have been liable if the Policy had not been terminated.

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

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

Continuation 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 to find out if your Group is subject to the provisions of *COBRA*.

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

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

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

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

Continuation Coverage under State Law

Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage ends and if your coverage ends under the Policy as described below. This continuation applies to you if the Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Groups that are not subject to the terms of *COBRA*. You should call your Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.

- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.

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 180 days 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.

If a provider of ambulance services complies with the statutory provision for direct payment and that provider has not been paid from any other source, Allowed Amounts due to that provider will be paid directly to that provider instead of being paid to the Subscriber.

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.

If your Benefit plan includes an *Outpatient Prescription Drug Rider* and you need to file a claim, your claim should be submitted to:

Optum RX
PO Box 650629
Dallas, TX 75265-0629

Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us. You may assign your right to reimbursement under this Certificate to a dentist or oral surgeon provided (1) the dentist or oral surgeon does not charge you more than what the dentist/oral surgeon would charge an uninsured patient for the same services, and (2) the dentist or oral surgeon allows Us to review medical records, with at least 48 hours notice, during regular business hours.

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

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

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.

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.

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

How Do You Appeal a Claim Decision?

This section describes the process for appealing a (1) utilization review (UR) decision or (2) a benefit, network or administrative decision. The process you will need to use depends upon the type of issue you are trying to resolve. Please read the information in the Section carefully, as it describes what the different review procedures are and when and how to use them. If you are still not sure of the process to follow, call Customer Care at the telephone number shown on your ID card.

Copies of these procedures are available in many languages and can be forwarded to you subject to availability. We can also arrange to have an independent interpreter available, however our ability to provide this service depends on the availability of the interpreter. We may need to arrange to call you at a time when an interpreter is available. Additionally, you always have the right to designate a representative during this process.

Authorized Representatives

You have the right to use these procedures. It is your responsibility to initiate a Complaint or Appeal within the timeframes set forth in this Certificate of Coverage.

You may designate a person to act on your behalf, including your healthcare provider ("authorized representative"). For appeals of benefit determinations concerning urgent care, we are required to allow your healthcare provider, with knowledge of your condition, to act as your authorized representative without your written consent. A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without care or treatment that is the subject of the determination.

For all other circumstances, to authorize a representative to act on your behalf, you must provide us with written consent at the time your complaint or appeal is submitted. Because your medical records are privileged and confidential, and we want to ensure that you wish to appeal, you must submit an original signed written consent. Members who are 18 years of age or older, including a member's spouse or children, will need to provide their own signed written consent. If the member is a minor, a written consent must be signed by the member's parent or guardian.

Your authorized representative will only be authorized to act on your behalf and is required to comply with all of the conditions of your Certificate that would apply to you when you initiate any appeal or complaint. Your authorized representative is not entitled to obtain any benefits or rights under your Certificate.

Utilization Review (UR) Appeals

UR will occur whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. The utilization review appeals process should be used after you have received an initial adverse UR determination and you do not agree with our decision. All appeals are subject to a review by us to evaluate the medical necessity of the services. You may use this process to appeal adverse determinations relating to all UR determinations, regardless of whether the services requested by you or your authorized representative have not yet been rendered (pre-service), are currently being rendered (concurrent) or have already been rendered (post-service).

Please note: This UR appeals process should not be used for appeals relating to benefit, network or administrative issues.

UR appeals must be initiated within 180 days from receipt of an adverse determination (i.e., receipt of the determination notice). A decision may be rendered within the standard timeframes or may be expedited as described in this section.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Unless we have already issued a written determination, we will use our best efforts to provide written acknowledgement of the receipt of your appeal within 5 business days, but in no event later than 15 calendar days. Our decision to either uphold or reverse the adverse determination will be made and communicated to you as follows:

- Request for service (pre-service): Within 30 calendar days of our receipt of the appeal.
- Concurrent services for a member in an ongoing course of treatment (concurrent): Within 30 calendar days of our receipt of the appeal. In this instance, treatment will be continued without liability while your appeal is being reviewed.
- Coverage for services rendered (post-service): Within 60 calendar days of our receipt of the appeal.
- If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.
- This will be our final adverse determination. If you are not satisfied with our decision, you have the option of filing an External Appeal (explained in the section below, "External Appeals.")

Expedited/Urgent Utilization Review (UR) Appeals

You can expedite your UR appeal when:

- You receive an adverse determination involving continued or extended health care services, procedures or treatments or additional services while you are undergoing a course of continued treatment (concurrent) prescribed by a health care provider; or
- The timeframes of the non-expedited UR appeal process would seriously jeopardize your life, health or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the health condition, the timeframes of the non-expedited UR appeal process would cause you severe pain that cannot be managed without the care of treatment that was requested; or
- Your physician believes an immediate appeal is necessary because the timeframes of the non-expedited UR appeal process would significantly increase the risk to your health; or

- For a Substance - Related and Addictive Disorders Substance - Related and Addictive Disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.
- You have two available options for expedited reviews. **These options are not available for health care services that have already been rendered (post-service).**

1. Internal Expedited UR Appeal: This process includes procedures to facilitate a timely resolution of the appeal including, but not limited to, the sharing of information between your provider and us by telephone or facsimile. We will provide reasonable access to our clinical peer reviewer within one business day of receiving notice of an expedited UR appeal.

A decision will be rendered and communicated for an internal expedited UR appeal within the following timeframes:

- 24 hours from our receipt of the appeal when the service being appealed is for Substance - Related and Addictive Disorders Substance - Related and Addictive Disorder or co-occurring mental disorder; and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder.
- 48 hours or seventy-two hours after we receive the request if any portion of the forty-eight-hour period falls on a weekend from our receipt of the appeal for all other types of services.
- If you are not satisfied with the outcome of the expedited UR appeal, you may further appeal through the external appeal process. If we do not make a determination within 24/48 hours or seventy-two hours after we receive the request if any portion of the forty-eight-hour period falls on a weekend from our receipt of the appeal, the adverse determination will be reversed. The notice of an appeal determination will include the reasons for the determination. If the adverse determination is upheld on appeal, the notice will include the specific reason(s) and clinical rationale used to render the determination, a reference to the specific health benefit plan provisions on which the decision is based, a statement that you may receive from us, upon request and free of charge, reasonable access to and copies of all relevant documents. We will also include a notice of your right to initiate an External Appeal. A description of each process and associated timeframes will be included.
- If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.

2. External Expedited Appeal: You also have the option to seek review by an independent review organization in emergency or life-threatening circumstances. You may make a request to the Commissioner of Insurance for an expedited external appeal without first completing the internal appeals process if:

- The timeframe for completion of an expedited internal appeal may cause or exacerbate an emergency or life-threatening situation; or
- For a Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting; and
- You, or your provider acting on your behalf with your consent, have filed a request for expedited internal review.

If you choose this option, you must submit the appeal by contacting the Connecticut Insurance Department at P.O. Box 816, Hartford, CT 06142-0816 (telephone number: 860-297-3910). For more information on how to file an expedited external appeal, refer to External UR Appeals below.

Office of the Healthcare Advocate and the Division of Consumer Affairs

If we deny a requested service on the basis that the service is not Medically Necessary or because it is a contractual exclusion and you believe you have been given erroneous information, you have the right to contact either Connecticut's Office of the Healthcare Advocate or Division of Consumer Affairs for assistance. You may contact them at the address listed below:

State of Connecticut

Office of the Healthcare Advocate

P.O. Box 1543

Hartford, CT 06114

Telephone: 1-866-466-4446

E-mail: Healthcare.advocate@ct.gov

Consumer Affairs Division

P.O. Box 816

Hartford, CT 06142-0816

Telephone: 1-800-203-3447

E-mail: cid.ca@ct.gov

External UR Appeals

Under certain circumstances, you or, with your consent, your authorized representative or provider acting on your behalf, have a right to file an external appeal or expedited external appeal for the denial of coverage for services based on lack of Medically Necessary criteria or because the service is experimental or investigational for a particular medical condition. Benefit or administrative determinations are not eligible for external appeal; only utilization review issues are eligible for external appeal.

You or your authorized representative have the right to request an external UR appeal in the following situations:

- The service, procedure or treatment must otherwise be a covered service under this Certificate; and
- You must have received a final adverse determination through the UR appeals review, with a denial based on lack of medical necessity criteria or experimental/investigational treatment UNLESS it is determined that the timeframe for completion of an internal appeal may cause or exacerbate an emergency or life threatening situation. In an emergency or life-threatening situation, you or your authorized provider acting on your behalf with your consent would not need to complete the internal UR appeal in order to file for an external appeal.

How to File an External Appeal

To file an expedited external appeal, you can submit an application with the Connecticut Insurance Department immediately following receipt of our initial adverse determination or appeal determination.

If the expedited external appeal is not accepted on an expedited basis, and you have not previously completed the internal UR appeal process, you may resume the internal appeal process until all internal appeals are exhausted. You may then file for a standard external appeal within 120 days following receipt of the final denial letter.

If the internal appeals were previously exhausted, your rejected expedited appeal will automatically be eligible for consideration for standard external appeal. You are not required to submit a new application.

Remember: You may not file an expedited external review for services which have already been provided (post-service).

To file a non-expedited external appeal, you have 120 days to initiate the appeal through the State of Connecticut Insurance Department after you have completed the internal UR appeal or after We and you both agree to waive the internal appeal process

Requests for external appeals and expedited external appeals must be in writing on an external appeal application form. The application form will include instructions on how to complete and submit the form to the Commissioner. You or your authorized representative (and Provider, if applicable) must release all pertinent medical information concerning your medical condition and request for services. You may contact Connecticut's Insurance Department at the following address or telephone number:

Connecticut Insurance Department

PO Box 816

Hartford, CT 06142-0816

Attn: Utilization Review Nurse Coordinator

(860) 297-3910

For Overnight delivery only, please send Your application for External Review to:

State of Connecticut Insurance Department

153 Market Street

P.O. Box 816

Hartford, CT 06142-0816

860-297-3910

The following items must be included in your Appeal. Your Appeal will be rejected if all of these items are not included:

- A completed "request for External Appeal" form.
- An authorization form allowing us and your health care professional to release your medical information to the independent review organization.
- Evidence of being an enrollee of the plan (photocopy of your insurance card).
- Copies of all correspondence from us.
- A copy of the final determination letter indicating that all internal appeal mechanisms have been exhausted.
- A copy of your policy or certificate of coverage.

In addition to the required items outlined above, you may also submit any additional information relevant to your condition.

Following receipt of the request for external appeal or expedited external appeal, the Insurance Commissioner will forward the appeal to us so that we may confirm that your appeal is complete and satisfies the conditions listed below. We will complete this review within 5 business days for an external review request or within 1 day for an expedited external review request.

1. You are or were a member of the plan at the time of the event that is subject of the adverse determination.
2. The service in question reasonably appears to be a covered service under the Certificate but was denied because it does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

3. The service in question reasonably appears to be a covered Service under the Certificate but was denied because it is experimental or investigational for a particular medical condition, is not explicitly listed as an excluded benefit under your health benefit plan and your treating health care professional has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving your medical condition;
 - Standard health care services are not medically appropriate for you.
 - There is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment.

In addition, your treating health care professional:

- Has recommended a health care service or treatment that he/she certifies, in writing, is likely to be more beneficial to you, in his/her opinion, than any available standard health care services or treatments; or
 - Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat your condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the denied health care service or treatment is likely to be more beneficial to you than any available standard health care services or treatments.
4. You have completed at least the First Level Appeal process;
 5. You have provided all of the required information

Once we have completed our review, we will notify you, your authorized representative (if appropriate) and the Insurance Commissioner whether the appeal is complete and eligible for external review. We will communicate our findings in writing within 1 business day for an external appeal or on the day the review is completed for an expedited external appeal. If your appeal is not complete, the notice will include what information or materials are missing. If your appeal is not eligible, the notice will include the reason(s) it is not eligible. In either instance, you may appeal this determination to the Insurance Commissioner.

If your appeal is eligible for external review, the Commissioner will assign your appeal to an Independent Review Organization. We will send a notice to the Commissioner, you, and your authorized representative (if appropriate) informing you that 1) your external review or expedited external review has been accepted, and 2) that you have 5 business days from receipt of the notice to submit any additional information and where the additional information should be submitted. If additional information is submitted later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information.

We will forward the medical and treatment plan records we relied upon in making our determination to the Independent Review Organization. If the documentation represents a material change from the documentation upon which we based our adverse determination or denial, we will have the opportunity to consider the documentation and amend or confirm our adverse determination or denial. This review will not delay or terminate the external review.

The Independent Review Organization will make a determination with regard to the appeal within the following timeframes:

- External Reviews: within 45 days after assignment from the Commissioner
- External Review involving an experimental or investigational treatment: within 20 days after assignment from the Commissioner
- Expedited External Reviews: as expeditiously as your condition requires, but not later than:
 - 24 hours after assignment from the Commissioner when the service being appealed is for Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or

co-occurring mental disorder; and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder.

- 48 hours or seventy-two hours after we receive the request if any portion of the forty-eight hour period falls on a weekend from our receipt of the appeal after assignment from the Commissioner for all other types of services.
- Expedited External Reviews involving an experimental or investigational treatment: as expeditiously as your conditions requires, but not later than 5 days after assignment from the Commissioner

Upon completion of the review, the Independent Review Organization will communicate its decision in writing to you, your authorized representative (if appropriate), the Commissioner and to us. If the decision is to reverse or revise our initial or final adverse determination, we will immediately approve the coverage, subject to the terms and conditions of this Certificate. The decision will be binding.

Benefit/Administrative Appeals

The benefit/administrative appeals process is used after you have received an initial adverse determination concerning a claim for benefits or an administrative issue. Benefit issues include, but are not limited to: denials based on benefit exclusions or limitations and claims payment disputes. Administrative issues would include issues such as access to providers, eligibility or enrollment issues.

Please Note: Benefit and administrative issues do not include determinations concerning the medical necessity of covered services. If we have denied your claims or request for services because we believe the services are not Medically Necessary, do not use the process outlined in this section. Please refer to the above section, Utilization Review (UR) Appeals.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Within 3 business days of receipt of your appeal, we will send you a notice informing you of your right to submit to us any additional written material you would like us to consider as part of our review. The notice will also provide the address, telephone number and the name of the Department handling your appeal.

Benefit/administrative appeals must be initiated by you or your authorized representative within 180 days from receipt of an adverse determination (i.e., an Explanation of Benefits, Denial Notice) or, for other issues, from the date when you became aware of the issue that initiated the appeal.

We will provide you or your authorized representative or your provider with our written decision (by mail or electronic means) and the detailed reasons for our decision including clinical rationale (if applicable) and references to any specific plan provisions on which our decision was based within 20 business days of receipt of your appeal.

This will be our final position.

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 can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- 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.

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 and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, (other than long-term care contracts under the LTC Partnership Program in Connecticut), 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; other than long-term care contracts under the LTC Partnership Program in Connecticut), 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 the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the Plans involved. 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.

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.

End Stage Renal Disease

When a member has end stage renal disease (ESRD) and she/he has enrolled for Medicare coverage, Benefits are coordinated in accordance with the Medicare Secondary Payer Rules.

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.
- Notifying you of when the Policy ends.

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.

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

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

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

Notice

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

Statements by Group or Subscriber

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-Oxford 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. We will pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

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

This section is subject to the decisions rendered in Section 6: Questions, Complaints and Appeals, as you always have the right to file a complaint or appeal.

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.

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

Amendments to the Policy

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

Subject to applicable law, we have the right to subrogation and reimbursement. 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 fully return to us 100% of any Benefits you receive for that Sickness or Injury. 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. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying 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.
 - Providing any relevant information requested by us.

- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any 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.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the

Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- 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.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful 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. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- 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.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- 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, 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 this happens, we will explain the problem to you, and you must return the overpayment to us. If the refund is due from you do not return the overpayment to us within 60 days after receiving notification from us, 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. However, we will not initiate overpayment recovery efforts more than 24 months after the original payment was made unless we have a reasonable belief of fraud or intentional misrepresentation.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

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

Section 9: Defined Terms

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

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

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

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

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

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

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

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

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

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

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

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

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).

- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Applied Behavior Analysis - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

Autism Spectrum Disorder - means "autism spectrum disorder" as set forth in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

Behavior Therapy - any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Connecticut Commissioner of Social Services, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with Autism Spectrum Disorder, that are:

- Provided to children less than twenty-one years of age; and
- Provided or supervised by any of the following:
 - a behavior analyst who is certified by the *Behavior Analyst Certification Board*,
 - a licensed Physician, or
 - a licensed psychologist.
 - Behavioral Therapy is considered to be supervised by a behavior analyst, licensed Physician or licensed psychologist when the supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provided for each ten hours of behavioral therapy provided by the supervised provider.
 - Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorders.

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

Clinical Peer - will be used to evaluate the clinical appropriateness of an adverse determination and for external review determinations. A clinical peer is a physician or other health care professional who:

- (A) holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
- (B) for an urgent care review concerning
 - A child or adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or a child or adolescent mental disorder, holds (1) a national board certification in child and adolescent psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or child and adolescent mental disorder, as applicable, or
 - An adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or an adult mental disorder, holds (1) a national board certification in psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or adult mental disorders, as applicable.

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.

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.

Continuity of Care - If you are undergoing an active course of treatment when a provider leaves the network, you may be eligible for Continuity of Care. For purposes of Continuity of Care, the following definitions apply:

Active Course of Treatment:

- A Medically Necessary, ongoing course of treatment for a life-threatening condition; or
- A Medically Necessary, ongoing course of treatment for a serious condition; or
- Medically Necessary care provided during the second or third trimester of pregnancy; or
- A Medically Necessary, ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the covered person's condition or interfere with anticipated outcomes.
- **Life-Threatening Condition:** a disease or condition for which the likelihood of death is probable unless the course of such disease or condition is interrupted.
- **Serious Condition:** a disease or condition that requires complex ongoing care such as chemotherapy, radiation therapy or postoperative visits, which the Covered Person is currently receiving.
- **Treating Network Provider:** a Member's treating health care provider or a facility at which the Member is receiving treatment that is removed from or leaves a health carrier's network.
- If you receive notice from us that your Treating Network Provider is no longer in our Network, you may be able to continue to receive Covered Health Care Services from your former Network Provider on an in-network basis in the following instances:
- You are in your second or third trimester of pregnancy: You may receive Covered Health Care Services through delivery and any post-partum care directly related to the delivery.
- You are undergoing an active course of treatment: We may extend in-network coverage to the earliest of the following:
 - ◆ Termination of the course of treatment by you or your treating provider; or
 - ◆ 90 days after the treating provider is removed from or leaves the network, unless Our Medical Director determines that a longer period is necessary; or
 - ◆ The date that care is successfully transitioned to another network provider; or
 - ◆ The date the benefit limitations under the health benefit plan are met or exceeded; or
 - ◆ The date We determine care is no longer Medically Necessary.
 - ◆ Continuity of Care is available only if the provider agrees to continue to follow Our reimbursement rates, policies and procedures. If the provider so agrees, you will receive these Covered Health Care Services as if they are being provided by a network provider. You will only be responsible for the in-network cost share, which will be applied to the in-network deductible and Out-of-Pocket Limit, if applicable to your plan. Pregnancies that are affected by this provision are automatically covered on an in-network basis.

If the Treating Network Provider was terminated by Us due to quality of care, Continuity of Care is not available.

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

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

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

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

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

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

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

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

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

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

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

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

The Dependent age limit will be specified in your *Schedule of Benefits*, including if your Group has chosen a Dependent age above 26.

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

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

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

Designated Provider - a provider and/or facility that:

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

A Designated Provider may or may not be located within the Service Area. Not all Network Hospitals or Network Physicians are Designated Providers.

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

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

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

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

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

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

- Placing the 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.

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, except that coverage is provided for a drug which has been prescribed for treatment of certain types of cancer for which the drug has not been approved by the *FDA*, provided the drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following three established reference compendia: (1) *The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital's Pharmacist's American Hospital Formulary Service Drug Information (AHES-DI)*. However, there is no coverage for any drug which the *FDA* has determined to be contraindicated for the specific cancer for which the drug has been prescribed.

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

except that Benefits for a procedure, treatment or the use of any drug will not be denied as experimental if such procedure, treatment or drug, for the illness of condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase 3 clinical trial.

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.

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

Genetic Testing - 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 - an agency or organization which meets all of the following:

- Is primarily engaged in and is federally certified as a home health agency and is duly licensed (if such licensing is required) by the appropriate licensing authority to provide nursing and other therapeutic services.
- Has their policy established by a professional group associated with the agency or organization, including at least one Physician and at least one registered nurse, to govern the services provided.
- Provides for full-time supervision of such services by a Physician or by an advanced practiced registered nurse.
- Maintains a complete medical record on each patient.
- Has an administrator.

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.

Individual Treatment Plan - a treatment plan prescribed by a Physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

Medically Necessary - health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.

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, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), 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.

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, or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

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. In determining whether health care services are Medically Necessary, we reserve the right to consult a subject matter expert of our choice and apply physician relevant specialty society recommendations.

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.

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 *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic*

and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Care Service. Mental or nervous conditions" does not include additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service. Mental or nervous conditions" does not include additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

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.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* Criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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

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

Out-of-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 - 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, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

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

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

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

- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

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

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

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

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

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

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

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a 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 if you have Benefits for Outpatient Prescription Drugs, while presented in Rider format, they 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.

Service Area - the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

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

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

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

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

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

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

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *Diagnostic and Statistical Manual of 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/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Surprise Bill - A bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider or out-of-network clinical laboratories, where such services were rendered by such out-of-network provider or out-of-network clinical laboratories, at an

in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider.

A "surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network or out-of-network clinical laboratories.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

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

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

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

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

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

Please note:

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

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Outpatient Prescription Drug Rider

Oxford Health Plans (CT), Inc.

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 Oxford Health Plans (CT), Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *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*.



Stephen J. Farrell

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.

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 or Co-insurance and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You

may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, by contacting us at www.myuhc.com or the telephone number on your ID card.

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. We will 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.

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc.com or the telephone number on your ID card.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you must meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your *Certificate*, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

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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 Drugs section of the Schedule of Benefits for applicable Co-payments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service including any medically necessary FDA approved Drug to treat a covered injury or sickness or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drugs* section of the *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. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
4. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to drugs for the treatment of a disabling or life-threatening chronic disease or cancer that have not been approved by the *Federal Food and Drug Administration* for that indication, if the drug has been prescribed for a Covered Person who has been diagnosed with a disabling or life-threatening chronic disease or cancer, provided the drug is recognized for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed in one of the following established reference compendia: (1) *The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI)*. This exception does not provide coverage for any experimental or investigational drugs or any drug which the *Federal Food and Drug Administration* has determined to be contraindicated for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws, subject to applicable law.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
11. Certain unit dose packaging or repackagers of Prescription Drug Products.

12. Medications used for cosmetic purposes, except for medications prescribed for gender identity reasons as outlined in your *Certificate of Coverage*. These medications require medical necessity review by Us.
13. 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, except that such review and approval of new Prescription Drug Products and/or new dosage forms will not be required for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in a substantially accepted peer-reviewed medical literature.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Prescription Drug Products when prescribed to treat infertility except that infertility coverage is available for Covered Persons with the following limitations: Prescription Drug Products associated with IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful.
16. Certain Prescription Drug Products for tobacco cessation.
17. 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 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 either Tier 2 or Tier 3.)
18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
19. Growth hormone therapy. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
20. Any product for which the primary use is a source of nutrition, nutritional supplements, ordinary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury except for the following products when administered under the direction of a Physician: 1) amino acid modified preparations and low protein medical food products for the treatment of inherited metabolic diseases, as defined by state law; and 2) Specialized Formulas when such Specialized Formulas are Medically Necessary for the treatment of a disease or condition.
21. A Prescription Drug Product that contains marijuana, including medical marijuana unless prescribed as a treatment for pain management.
22. A Prescription Drug Product with either:
 - An approved biosimilar.
 - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product.
- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

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

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

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.

Infertility - not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

- One year, if you are a female under age 35.
- Six months, if you are a female age 35 or older.

In addition, in order to be eligible for Benefits, you must also:

- Have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

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

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Out-of-Pocket Drug Limit - the maximum amount you pay for covered Prescription Drug Products every year. The *Outpatient Prescription Drugs* section of the *Schedule of Benefits* will tell you how the Out-of-Pocket Drug Limit applies.

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*.
- 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.

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. The amount you pay for a prescription will be the lesser amount of the drug, you will not have to pay the applicable copayment if the drug cost is less.

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.
- Hypodermic needles or syringes
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:

- standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
 - glucose meters, including continuous glucose monitors.
 - any medically necessary diabetic supplies.
- Topical dental preparations.

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.

Specialized Formula - A nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products include 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 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.

UnitedHealthcare Rewards Rider

Oxford Health Plans (CT), Inc.

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 Oxford Health Plans (CT), Inc. 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 wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

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

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health 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. |
| Active - Fitness | 30 minutes or more of activity as designated by the program or 10,000 or more steps per day | |
| Other Health-Related Actions and/or Activities | One or more actions and/or activities defined by us and aimed at the following: <ul style="list-style-type: none"> • Health education; • Improving health; or | |

| | | |
|--|----------------------|--|
| | • Maintaining health | |
|--|----------------------|--|

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

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

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

Rewards

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

Device

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



Stephen J. Farrell

President

Sweat Equity Fitness Reimbursement Rider

Oxford Health Plans (CT), Inc.

This Rider to the Policy is issued to the Group and provides a description of the Sweat Equity Fitness Reimbursement 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 (Certificate)* in *Section 9: Defined Terms*.

When we use the words "we", "us", and "our" in this document, we are referring to Oxford Health Plans (CT), Inc.. When we use the words "you" and "your" we are referring to the Subscriber and Spouse and Enrolled Dependents.

Sweat Equity Fitness Reimbursement Program

The purpose of this fitness reimbursement program is to encourage you to take a more active role in managing your health and well-being.

We will provide partial reimbursement for eligible fees associated with certain exercise that promotes cardiovascular wellness as described below.

Exercise activity fees include costs you pay for exercise facility fees, or exercise facility and class membership fees, outdoor bike rentals, organized group exercise classes, individual fitness instruction, organized group physical event, such as a marathon but only if such fees are paid to facilities or organizations which maintain equipment and/or offer programs, which may include certain digital application-based exercise programs, that promote cardiovascular wellness and are available to the general public. You can call us at the telephone number on your ID card for the current list of any eligible digital application-based exercise programs.

Membership in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits, organized group exercise classes, sessions, bike rides or organized group physical events. We will not provide reimbursement for the purchase of equipment, clothing, vitamins or other items or services that may be offered by the facility or organization (e.g., massages, etc.).

In order to be eligible for reimbursement, you must:

- Be an active member of the facility or program, attend organized group classes at the exercise facility or organization, and
- Complete a combined total of 50 visits, organized group classes, sessions, bike rides or organized group physical events in a six-month period.

In order to obtain reimbursement, at the end of the six-month period, you must submit:

- A completed reimbursement form from the facility or program of your visits, sessions, and events. Each time you use the exercise facility, a facility representative must sign and date the reimbursement form; documentation of the visits, such a system-generated, dated accounting of your workout(s).
- A copy of your current facility bill(s), class or program bill which shows the fee paid for your class membership, workout visits, organized group classes, sessions, bike rides or organized group physical events.
- A copy of the brochure or website printout that outlines the services or programs the exercise facility, class, session or event offers.

Once we receive the completed reimbursement form; documentation of the visits and the facility, class, event, or program bill(s), the Subscriber will be reimbursed up to \$200 and each Enrolled Dependent will be reimbursed up to \$100 or the actual cost of the eligible facility, class, program, session, event or membership per six month period, whichever is less. If you are unable to meet a standard related to a health factor for reimbursement under this fitness reimbursement program, you might qualify for an opportunity to earn the same reward by different means. Call us at the number on your identification (ID card, and we will work with you and, if necessary, your Physician, to find another way for you to earn the same reward.

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

Reimbursement must be requested within 120 days of the end of the six-month period. Reimbursement will be issued only after you have completed each six-month period even if 50 visits are completed sooner.



Stephen J. Farrell

President

Real Appeal Rider

Oxford Health Plans (CT), Inc.

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 13 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.



Stephen J. Farrell

President

Dependent Age Limit

The Dependent age limit is 26. Coverage ends upon the Policy's anniversary date.

Domestic Partner Rider

Oxford Health Plans (CT), Inc.

This Rider to the Policy is issued to the Group and provides coverage for Domestic Partners.

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 the Certificate of Coverage (*Certificate*) in *Section 9: Defined Terms* and in this Rider below.

When we use the words "we", "us", and "our" in this document, we are referring Oxford Health Plans (CT), Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Coverage for Domestic Partners

The provisions below replace the provision shown in the *Certificate* in order to add coverage for Domestic Partners when they are enrolled as Dependents of Subscribers.

Section 3: When Coverage Begins

The section titled Adding New Dependents in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 (61 days for newborns) of the event.

The section titled Special Enrollment Period in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 (61 days for newborns) days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day 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 9: Defined Terms

The definition of Dependent in the Certificate under Section 9: Defined Terms is replaced with the following:

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*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

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

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the policy anniversary date following the date the child reaches age 26.

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

The following definitions of Domestic Partner and Domestic Partnership are added to the Certificate under Section 9: Defined Terms:

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 and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - They have a single dedicated relationship of at least 6 - 18 months.
 - They have joint ownership of a residence.
 - They have at least two of the following:

- ◆ A joint ownership of an automobile.
- ◆ A joint checking, bank or investment account.
- ◆ A joint credit account.
- ◆ A lease for a residence identifying both partners as tenants.
- ◆ A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.



Stephen J. Farrell
President

Zero Cost Share Medications Addendum

Oxford Health Plans (CT), Inc.

As described in this addendum, certain Prescription Drug Products as described in the *Outpatient Prescription Drug Rider* and *Schedule of Benefits* are modified as stated below.

Because this addendum 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 (Certificate)* in *Section 9: Defined Terms*, in the *Outpatient Prescription Drug Rider* in *Section 3: Defined Terms*, and in this addendum below.

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Plans (CT), Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

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

The following definition is added to *Section 3: Defined Terms* in the *Outpatient Prescription Drug Rider*:

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). 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.

The List of Zero Cost Share Medications includes certain Prescription Drug Products under these drug classes or categories:

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



Stephen J. Farrell
President

Federal Notices



Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or 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. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

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をご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ **ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយគេគឺឥតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohji' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ:·Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας· Παρακαλείστε να καλέσετε 1-866-633-2446.

ध्यान आपो:·જો તમે **ગુજરાતી (Gujarati)** બોલતા છો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.

કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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 60 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 1-866-633-2446 or 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. ET

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

¹For purposes of the Language Assistance Services and 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 you 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 NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2023:

We² are required by law to protect the privacy of your health information. We are also required to send 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.

The terms "information" or "health information" in this notice include any 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, such as www.myuhc.com. 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 make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may collect, use, and disclose health information needed 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. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **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 Sponsors.** 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. In addition, we 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.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or 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.** We may communicate, electronically or via telephone, these 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:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps 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 interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. 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.
- **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.** We may disclose your health information 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.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information 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 and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 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 Health

11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated 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 promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the 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. To find out where to mail your written authorization and how to revoke an 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** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures 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. **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 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 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 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 will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. 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 or have your information sent to a third party. 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. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive 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; and (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, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. 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 exercising 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.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
 PO Box 740815
 Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint 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.

²This Medical Information 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; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; 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.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; 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, 2023

We³ 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.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices 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 ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, 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, 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*.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- o **Online:** UHC_Civil_Rights@uhc.com
- o **Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- o **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

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

- o **Phone:** Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
- o **Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue. SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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をご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្វែងរកជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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ACCESS REQUEST FORM

Purpose: This Form is intended for use by an individual to exercise his/her right to access his/her protected health information in Oxford's designated record sets or the designated record sets of Oxford's Business Associates.

Individual Seeking Access

Name: _____

Address: _____

I.D. Number: _____

Telephone: _____

Scope of Access

You have the right to inspect and obtain a copy of your protected health information maintained by Oxford and its business associates. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have or any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding.

Please specify the records you wish to inspect or obtain copies of:

We may charge you to make copies and mail your protected health information. Oxford will notify you in advance of these charges. If you want to pick the copies up at our Shelton, CT office please check here _____

Signature: _____

Date: _____

Personal Representative

If this request is being made by a personal representative on behalf of the individual, please provide a description and any available documentation of authority to act as the individual's personal representative and sign below.

Print name _____

Signature _____

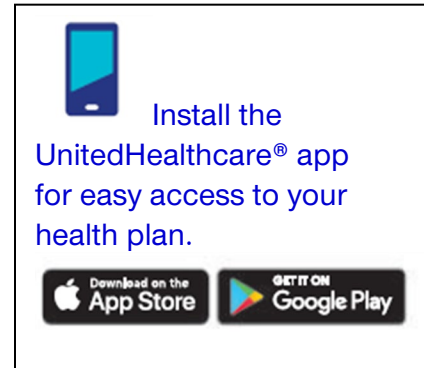
Please send completed form to:
UnitedHealthcare
HIPAA Member Rights Unit
P.O. Box 29130
Hot Springs, AR 71903

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.



Dear Oxford member,

Welcome, and thank you for selecting an Oxford plan. Your satisfaction is important to us; we want your health care benefits experience to be a positive one. As an Oxford member you have access to a host of resources, programs and tools—all meant to help you use your benefits, take charge of your health and get the most out of your plan. Following are highlights of several key plan features:



Network access

We have a large network of providers located throughout the Oxford tri-state service area.¹ Using network doctors, mental health professionals, hospitals, clinics, and laboratories typically saves you money. Most Oxford plans also include out-of-area coverage through UnitedHealthcare national networks if you live or travel outside the Oxford service area.² Use the provider search tool on the member website, **myuhc.com**[®], or through the UnitedHealthcare[®] app to look up network providers for your plan. You can also call us for assistance at the phone number on your health plan ID card.

Your personal member website and app

A self-service health plan member website, **myuhc.com**, allows you convenient, around-the-clock access to information about your health benefits, the ability to request a health plan ID card, locate a participating provider, update your personal information, and more. Register on the website and download the UnitedHealthcare app for help staying connected to your benefits.

UnitedHealthcare Rewards³

You can earn up to \$300 in a plan year for a variety of healthy actions — including things you may already be doing, like tracking your steps or getting a biometric screening. Your total earnings potential may vary based on your health plan. Find out more by signing in to the UnitedHealthcare app, select the Me tab and then Rewards. Or sign in to **myuhc.com > Rewards**.

Sweat Equity[®] Program

This wellness program offers you reimbursement toward your cardio-based physical fitness expenses—up to \$200 two times per plan year—after meeting the program requirements.⁴

Cancer support

Led by experienced cancer nurses with assistance from a board-certified medical oncologist, a hematologist, and other doctors, as well as social workers, this program offers compassionate guidance and answers for you or a family member who's faced with cancer. Call **1-866-936-6002** for support.⁵

Behavioral health solutions

For life's challenges, support is here. You have access to a 24/7 substance use help line, as well as a website dedicated to mental health and substance use resources. Call the helpline at **1-855-780-5955** 24 hours a day, 7 days a week.

continued...

Centers of Excellence

These providers are identified for meeting our quality assessment criteria and being in good standing with us and national accreditations. They have demonstrated their ability to deliver cost-effective care for complex medical conditions and other services and procedures.⁶

More information

If you have questions about this information or your coverage, or if you want to learn more about available programs and resources, sign in to **myuhc.com** or call us at the toll-free number on your health plan ID card.

Wishing you the best of health,

The Oxford Team

¹ The Oxford tri-state area includes Connecticut, New Jersey, and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau, and Suffolk). Network access may vary by plan.

² National network access may vary by plan and may not be available for all groups, including groups with an Oxford Metro Network[®] plan. Network participation subject to change.

³ UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico nor available to level funded members in District of Columbia, Hawaii, Vermont and Puerto Rico.

⁴ Reimbursement is generally limited to the lesser of \$200 (subscriber)/\$100 (covered spouse/partner) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. Refer to your benefits documents or check with your benefits administrator to find out how much you may be reimbursed. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

⁵ The Cancer Support program **should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.** The information provided through this service is for informational purposes only and provided as part of your health plan. The nurse cannot diagnose problems or recommend treatment and is not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. This nurse support service is not an insurance program and may be discontinued at any time.

⁶ The Centers of Excellence (COE) program providers and medical centers are independent contractors who render care and treatment to health plan members. The COE program does not provide direct health care services or practice medicine, and the COE providers and medical centers are solely responsible for medical judgments and related treatments. The COE program is not liable for any act or omission, including negligence, committed by any independent contracted health care professional or medical center.

The UnitedHealthcare[®] app is available for download for iPhone[®] or Android[®]. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

UnitedHealthcare and Oxford do not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card 8 a.m. – 6 p.m. ET, Monday – Friday. TTY users can dial 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación. 請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Oxford HMO products are underwritten by Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc.

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CT/NJ/NY Oxford Welcome Letter 01/24

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Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to myuhc.com, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to myuhc.com or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.



Oxford Health Insurance, Inc.

Large Business Market

KACTOHIHC01DR1

Schedule of Benefits

Non-Tiered Network Plan

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|--|--|
| Plan Deductible Individual Family | \$3,000 per Covered Person. \$3,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family. | \$10,000 per Covered Person. \$10,000 per Covered Person, not to exceed \$20,000 for all Covered Persons in a family. |
| Separate Prescription Drug Deductible Individual | N/A | N/A |
| Out-of-Pocket Maximum Individual Family (Includes deductibles, copays and coinsurance) | \$7,000 per Covered Person. \$7,000 per Covered Person, not to exceed \$14,000 for all Covered Persons in a family. | \$20,000 per Covered Person. \$20,000 per Covered Person, not to exceed \$40,000 for all Covered Persons in a family. |
| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
| Provider Office Visits | | |
| Adult/Pediatric Preventive Visits (including Preventive Mammography and Tomosynthesis) | No Cost | 50% after OON deductible is met |
| Primary Care Provider Office Visit (includes services for illness, injury, follow-up care and consultations) | \$30 per visit | 50% after OON deductible is met |
| Specialists Office Visits | \$70 per visit | 50% after OON deductible is met |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| Mental Health and Substance Abuse Office Visits | \$70 per visit | 50% after OON deductible is met |
| Outpatient Diagnostic Services | | |
| Advanced Radiology (CT/PET Scan, MRI) | Freestanding Facility: 20% per visit after INET deductible is met Hospital Based: 20% per visit after INET deductible is met | 50% after OON deductible is met |
| Laboratory Services Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year. For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider. | Designated Network \$25 per service Network 50% per service after INET deductible is met | 50% after OON deductible is met |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$50 per service | 50% after OON deductible is met |
| Mammography Ultrasound Please refer to the Certificate for further information on this benefit coverage. | No Cost | 50% after OON deductible is met |
| Prescription Drugs – Retail Pharmacy (31 day supply per prescription) | | |
| Tier 1 | \$5 copayment per prescription | 50% after OON deductible is met |
| Tier 2 | \$50 copayment per prescription | 50% after OON deductible is met |
| Tier 3 | 30% coinsurance up to \$500 maximum per prescription | 50% after OON deductible is met |
| Tier 4 | 50% coinsurance up to \$750 maximum per prescription | 50% after OON deductible is met |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| Prescription Drugs – Mail Order Pharmacy (90 day supply per prescription) | | |
| Tier 1 | \$10 copayment per prescription | 50% after OON deductible is met |
| Tier 2 | \$100 copayment per prescription | 50% after OON deductible is met |
| Tier 3 | 30% coinsurance up to \$1,000 maximum per prescription | 50% after OON deductible is met |
| Tier 4 | 50% coinsurance up to \$1,500 maximum per prescription per prescription | 50% after OON deductible is met |
| Outpatient Rehabilitative and Habilitative Services | | |
| Speech Therapy 60 visits per year limit combined for Rehabilitative (physical, speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, physical and occupational therapies). | \$30 per visit | 50% after OON deductible is met |
| Physical and Occupational Therapy 60 visits per year limit combined for Rehabilitative (physical, speech, and occupational therapies); Separate 60 visits per year limit combined for Habilitative (speech, physical and occupational therapies). | \$30 per visit | 50% after OON deductible is met |
| Other Services | | |
| Chiropractic Services (up to 30 visits per year for Rehabilitative chiropractic services, separate 30 visits per year limit for Habilitative chiropractic services.) | \$70 per visit | 50% after OON deductible is met |
| Diabetic Equipment and Supplies For medically necessary covered | Supplies obtained from your Physician are subject to the | 50% after OON deductible is met |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|--|---|
| <p>insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$25 for an individual prescription of up to a 30-day supply.</p> <p>For medically necessary covered noninsulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$25 or an individual prescription of up to a 30-day supply.</p> <p>For medically necessary covered diabetes devices and diabetic ketoacidosis devices the total amount of Deductible, Co-payments or Co-insurance shall not exceed \$100 for an individual prescription of up to a 30-day supply.</p> | <p>applicable Physician Cost Share.</p> <p>Supplies obtained through the pharmacy are subject to the applicable Pharmacy cost share based on Tier.</p> | |
| Durable Medical Equipment (DME) | 20% per item after INET deductible is met | 50% after OON deductible is met |
| Home Health Care Services (up to 100 visits per year) | 20% per visit | 25% |
| Outpatient Services (in a hospital or ambulatory facility) | <p>Freestanding Facility: 20% per service after INET deductible is met</p> <p>Hospital Based: 20% per service after INET deductible is met</p> <p>Please refer to your provider directory to identify freestanding facilities and hospital-based</p> | 50% after OON deductible is met |
| Prosthetic Services | 20% per item after INET deductible is met | 50% after OON deductible is met |
| <p>Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility and all Inpatient settings.</p> <p>(skilled nursing facility stay and inpatient rehabilitation is limited to</p> | 20% per admission after INET deductible is met | 50% after OON deductible is met |

| Benefit | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|--|--|-------------------------------------|
| 90 days per year combined) | | |
| Emergency and Urgent Care | | |
| Ambulance Services Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> . | 20% per service after INET deductible is met | Same as INET |
| Emergency Room | \$150 per visit | Same as INET |
| Urgent Care Centers | \$70 per visit | 50% after OON deductible is met |

Important Information:

ADDITIONAL INFORMATION: MEDICAL SERVICES

What Will You Pay for Covered Health Care Services?

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Emergency Health Care Services – Outpatient

If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, 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.

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.

Benefit Limitations

The benefits listed below have the following limitations:

Outpatient Rehabilitation and Habilitative Services:

Post-Cochlear Implant Aural Therapy is limited to 60 visits per year for Rehabilitative post-cochlear implant aural therapy and a separate 60 visits per year limit for Habilitative.

Cognitive Therapy is limited to 60 visits per year for Rehabilitative cognitive therapy and a separate 60 visits per year for Habilitative.

Hearing aids

Hearing Aids will be covered once every 24 months.

The above limit does not apply to over-the-counter hearing aids. For over-the-counter hearing aids, Benefits are limited to \$1,000 every year. Benefits are further limited to a single purchase every year.

Fertility Preservation for Iatrogenic Infertility:

Benefit limits will be the same as, and combined with, those stated under *Infertility Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.

Preimplantation Genetic Testing (PGT) and Related Services:

Benefit limits for related services will 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.

This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider*.

Pharmaceutical Products – Outpatient

Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical 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 Specialty Pharmaceutical Products and the applicable Co-payment and/or Co-insurance.

Accessing 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.

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*.

Does Prior Authorization Apply?

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

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.

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.

For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the

amount you are required to pay will be reduced by 50% of the Allowed Amount, however, the amount of the reduction will not exceed \$500 per occurrence.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply.

- **Ambulance** - 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.
- **Breast pumps.** For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.
- **Cellular and Gene Therapy** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises.
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.
- **Clinical trials.** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.
- **Congenital Heart Disease (CHD) Surgeries** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises
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.
- **Diabetes Services** For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes (either retail purchase cost or cumulative retail rental cost of a single item).
- **Durable Medical Equipment (DME), Orthotics and Supplies** For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than \$500 (either retail purchase cost or cumulative retail rental cost of a single item).
- **Fertility Preservation for Iatrogenic Infertility** For Out-of-Network Benefits, you must obtain prior authorization as soon as possible.
- **Gender Dysphoria** - For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises.

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*

- **Habilitative Services** 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.

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.

For Out-of-Network Benefits for outpatient therapies, you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment, speech therapy, post-cochlear implant aural therapy, and cognitive therapy or as soon as is reasonably possible.

- Home health care. For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.
- Hospice care 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.

In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.

- **Hospital - Inpatient Stay** - 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.

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.

- **Infertility services.** For Out-of-Network Benefits, you must obtain prior authorization as soon as possible.
- **Lab, X-Ray and Diagnostic – Outpatient** 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.
- **Major Diagnostic and Imaging – Outpatient** 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.
- **Mental Health Care and Substance-Related and Addictive Disorders Services** - 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 (prior authorization is not required for neuropsychological testing for children diagnosed with cancer).

In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

- **Obesity - Weight Loss Surgery** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of obesity - weight loss surgery arises.

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 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.

- **Pharmaceutical Products – Outpatient** For Out-of-Network Benefits, you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.

For Out-of-Network Benefits, you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. You may find out whether a particular Pharmaceutical Product requires prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

- **Pregnancy - Maternity Services-** 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.
- **Preimplantation Genetic Testing (PGT) and Related Services** For Out-of-Network Benefits, you must obtain prior authorization as soon as possible.
- Prosthetic devices. For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices.
- **Reconstructive Procedures-** 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.

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.

- Rehabilitation services and **Chiropractic Treatment** - physical therapy, occupational therapy, Chiropractic Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy. For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy or as soon as is reasonably possible.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic. For Out-of-Network Benefits, 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.
- **Skilled Nursing Facility and Inpatient Rehabilitation Facility services.** 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.

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 (including Emergency admissions).

- **Spine and Joint Surgeries** For Out-of-Network Benefits, you must obtain prior authorization for spine and joint surgeries.
- **Surgery – Outpatient** For Out-of-Network Benefits for all outpatient surgeries, 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.
- **Temporomandibular Joint (TMJ) Services** 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.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.

- **Therapeutic Treatments – Outpatient** For Out-of-Network Benefits, you must obtain prior authorization for all outpatient therapeutic services five business days before scheduled services

are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.

- **Transplantation Services** For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

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.

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

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

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

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

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Care Services.

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.

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Designated Network Benefits and 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*.

Designated Network Benefits and Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network Benefits and 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 Act with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The provider may bill us directly and we will reimburse the provider the greatest of the following amounts:
 - The amount we would pay for such services if rendered by an in-network health care provider;
 - The usual, customary and reasonable rate for such services; or
 - The amount Medicare would reimburse for such services.

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.
 - 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. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for help.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If you are diagnosed with a condition or disease that requires specialty care and either we do not have a Network provider with the required specialty training or if access to a Network provider would require unreasonable travel or delay, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and/or your Network Physician to coordinate care through an out-of-Network provider.

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.

II. ADDITIONAL INFORMATION: OUTPATIENT PRESCRIPTION DRUGS

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 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 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.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Tiers

Prescription Drug Products are categorized into cost tiers. Tier one contains lower cost generic drugs. Tier 2 contains preferred lower cost brand drugs. Tier 3 typically contains non-preferred brand drugs. Tier 4 typically contains higher cost brand drugs.

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.

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.

Prescription Drug Products which require prior notification are listed below.

Prescription Drug Products which require Notification: Absorica, Abstral, Actemra (subcutaneous formulation), Actimmune, Actiq, Adcirca, Adderall, Adderall XR, Adempas, Afinitor, Alecensa, Amitiza, Amnesteem, Ampyra, Aptiom, Arcalyst, Atralin, Aubagio, Avita, Avodart, Avonex, Banzel, Berinert, Betaseron, Bethkis, Bosulif, Brilinta, Bunavail, Caprelsa, Cayston, Cerdelga, Cholam, Cimzia, Cinryze, Claravis, Cometriq Compounds and Bulk Powders, Concerta, Copaxone, Cosentyx, Cotellic, Crinone, Cystaran, Daklinza, Daliresp, Daytrana, Desoxyn, Dextredreine, Dextrostat, Differin, Egrifta, Elidel, Eligard, Elocatate, Enbrel, Endometrin, Entresto, Epanova, Erivedge, Esbriet, Evekeo, Exjade, Extavia, Fabior, Farydak, Fentanyl citrate compounds, Fentora, Ferriprox, Firazyr, First Progesterone, Focalin, Focalin XR, Forteo, Fulyzaq, Fycompa, Gattex, Genotropin (excluded), Gilenya, Gilotrif, Gleevec, Grastek, H.P. Acthar, Harvoni, Hettioz, Humatrope (excluded), Humira, Hycamtin, Ibrance, Iclusig, Imbruvica, Increlex, Infergen, Inlyta, Intron A, Iressa, Jadenu, Jakafi, Jublia, Juxtapid, Kalydeco, Kerydin, Keveyis, Kineret, Kitabis Pak, Korlym, Kuvan, Kynamro, Lazanda, Lenvima, Letairis, Linzess, Lonsurf, Lotronex, Lovaza, Lynparza, Mekinist, Metadate, Metadate CD, Metadate ER, Movantik, Multaq, Myalept, Myorisan, Natpara, Nexavar, Ninlaro, NordiFlex, Norditropin (excluded), Nutropin, Nutropin AQ, Nutropin AQ NuSpin, Nuvigil, Odomzo, OFEV, Olysio, Omnitrope (excluded), Omtryg, Onfi, Opsumit, Oralair, Orenica (subcutaneous formulation), Orenitram, Orkambi, Otezla, Peg-Intron/Pegasys, Plegridy, Pomalyst, Potiga, Praluent, ProCentra, Procysbi, Promacta, Protopic, Porvigil, Pulmozyme, Quillivant XR, Ragwitek, Ravicti, Rebif, Rebif Rebidose, Rectiv, Regranex, Repatha, Restasis, Retin-A, Retin-A Micro, Revatio, Revlimid, Ritalin, Ritalin LA, Ritalin SR, Ruconest, Saizen, Sandostatin/octreotide, Selzentry, Serostim, Signifor, Simponi, Sirturo, Solaraze, Sotret, Sovaldi, Sprycel, Stelara, Stivarga, Stremsiq, Suboxone/Subutex, Subsys, Sutent, Sylatron, Syprine, Tafinlar, Tagrisso, Tarceva, Targretin, Tassigna, Tazorac, Tecfidera, Technivie, Temodar, Thalomid, TOBI, TOBI Podhaler, Tracleer, Tretinoin cream, Tretinoin gel, Tretin-X, Tykerb, Tyvaso, Upravi, Valchlor, Vascepa, Vecamyl, Ventavis, Victrelis, Viekira Pak, Vimpat, Votrient, Vyvanse, Xalkori, Xeljanz, Xtandi, Xyrem, Zelboraf, Zenatane, Zenzedi, Zomacton, Zontivity, Zorbitive, Zubsolv, Zydelig, Zykadia, Zytiga.

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* 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 or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under the *Outpatient Prescription Drug Rider* are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

This step therapy process will not require you to use an alternative brand name prescription drug or over-the-counter drug prior to using a brand name prescription drug that has been prescribed by a licensed physician for pain treatment. We may require you to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug. Step therapy is not required for a prescribed drug for cancer treatment for a Covered Person who has been diagnosed with state IV metastatic cancer when the prescribed drug is in compliance with approved federal Food and Drug Administration indications.

Prescription Drug Products subject to step therapy requirements: H.P. Acthar, Cystagon, Depakote, Depakote ER, Stavzor, Keppra, Keppra XR, Lamictal, Lamictal ODT, Lamictal XR, Lamotrigine ER, Lamotrigine ODT, Neurontin, Tomamax, Trileptal, Oxtellar XR, Qudexy XR, Zonegran, Trokendi XR, Cialis (tadalafil) 2.5 & 5 mg, Bosulif, Sprycel, Xtandi, Amitiza, Brintellix, Fetzima, Inokana, Jardiance, Farxiga, Januvia, Janumet, Janument XR, Xigduo XR, Glyxambi, Trulicity, Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog Mix 70/30, Apidra, Apidra SoloStar, Afrezza, Oxistat, Jublia, Kerydin, Uloric, Nexium suspension (esomeprazole), Prevacid SoluTab (lansoprazole), Olysio, Sovaldi, Victrelis, Viekria Pak, Peg-Intron, Repatha, Lescol XL, Livalo, Stribild, Genvoya, Bravelle, Follistim AQ, Resulti, Rasuvo, Otrexup, Aubagio, Gilenya, Rebif, Rebif Rebidose, Extavia, Rescula, Travoprost (generic Travatan), Zioptan (tafluprost), Butrans, Embeda, Avinza, Exalgo, Hysingla, Kadian, MS Contin (Brand Only), Oxycontin, Oxymorphone hcl ER (generic Opana ER), Pancreaze, Pertzye, Ultresa, Viokace, Otezla, Xeljanz, Actemra, Orencia, Enbrel, Cosentyx, Lyrica, Cordran SP cream (flurandrenolide).05% cream), Cordran Lotion (flurandrenolide 0.05% lotion, Desonate (desonide 0.05% gel), Cloderm cream (clocortolone pivalate 0.1% cream), Halog cream (halcinonide 0.1%), Halog ointment (halcinonide 0.1% ointment), Soolantra, Belsomra, Rozerem, Zolpmist, Zovirax ointment.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

What Do You Pay?

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any or Out-of-Pocket Limit.

The amount you pay for any of the following under the *Outpatient Prescription Drug Rider* will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- Ancillary Charges.
- 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.

Certificate of Coverage

Oxford Health Insurance, Inc.

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between Oxford Health Insurance, Inc. 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 Connecticut. The Policy is subject to the laws of the state of Connecticut and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Connecticut 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 Oxford Health Insurance, Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 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

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment or Co-insurance amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all 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.

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

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 develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. 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.

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 or are state/federally mandated:

- 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 requirements specified in the Policy.

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/Telemedicine. 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 or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Abortion Services

Benefits include services for a therapeutic abortion, that is an abortion recommended by a Provider performed to save the life or health of the mother, or as a result of incest or rape. The plan will also cover elective abortions.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the 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.

3. 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*.

4. 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.
- Disabling or life-threatening chronic disease.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - 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 patient care costs are subject to the terms, conditions, restrictions, exclusions and limitations of this Policy. If treatment is not available at an in-network facility, coverage may be provided at an Out-of-network hospital at no greater cost than if such treatment was available in-network.

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 disabling or 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 disabling or life-threatening diseases or conditions. 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 disabling or life-threatening diseases or conditions, 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 disabling or life-threatening diseases or disorders. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)* .)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

5. Dental Services - Accident Only

Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair (not replacement) of sound natural teeth when both of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

Please note that dental damage that happens as a result of normal activities of daily living (such as biting or chewing) or intentional misuse 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 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 include the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes. Diabetes outpatient self-management training, education and medical nutrition therapy services must be prescribed by a licensed health care professional who has appropriate state licensing authority. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. The training must be given by a certified registered or licensed health care professional trained in the care and management of diabetes.

Coverage includes:

- Initial training visit, up to 10 hours, after you are diagnosed with diabetes, for the care and management of diabetes, including but not limited to:
- Counseling in nutrition.
- The use of equipment and supplies
- Training and education, up to four hours, as a result of a subsequent diagnosis by a Physician of a significant change in your symptoms or condition which require modification of your program of self-management of diabetes.
- Training and education, up to four hours, because of the development of new techniques and treatments.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps, supplies and medications for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps which are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment.
- Insulin.
- Oral agents such as glucose tablets and gels.
- Glucagon for use with injection to increase blood glucose concentration.
- Blood glucose meters including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

If your Benefit plan includes an *Outpatient Prescription Drug Rider*, Benefits for diabetic medications and supplies may be provided as described in the Outpatient Prescription Drugs section of the *Schedule of Benefits*.

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 *Devices, Appliances, Medical Equipment and Prosthetics*.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

8. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Coverage includes Emergency Health Care Services due to accidental ingestion or consumption of a controlled drug. A "controlled drug" is a substance such as cocaine, morphine, hallucinogens, etc. It does not include alcohol, nicotine or caffeine.

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). This also includes coverage for isolation care and emergency services provided by the state's mobile field hospital.

Benefits do not include follow-up care provided in a Hospital Emergency room.

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions.

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 are provided for pharmaceutical products related to the treatment of fertility preservation that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or your home and as described under your *Outpatient Prescription Drug Rider*.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed 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.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

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.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

14. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by an advanced practice registered nurse (APRN), or a Physician.
- Provided in your home by a registered nurse, or advanced practice registered nurse (APRN), or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available for:

- Part-time intermittent home nursing care by or supervised by a registered professional nurse.
- Part-time or intermittent home health aide services.
- Home Health Agency services include physical, occupational or speech therapy.
- Benefits are available for the following items to the extent that they would have been available if the Covered Person were confined to a Hospital:
 - Medical supplies.
 - Drugs and medicine.
 - Laboratory services.
 - Medical social services, including but not limited to those provided to or for the benefit of a Covered Person diagnosed by a Physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live. Medical social services are services, rendered under the direction of a Physician or an advanced practice registered nurse, by a qualified social worker. These services include, but are not limited to:
 - Assessment of the social, psychological and family problems related to or arising out of such Covered Person's illness and treatment.
 - Appropriate action and utilization of community resources to assist in resolving such problems.
 - Participation in the development of the overall plan of treatment for such Covered Person.

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 including radiologists, anesthesiologists, pathologists and Emergency room Physicians.

We will pay Benefits for an Inpatient Stay of at least 48 hours following a mastectomy or lymph node dissection. We will pay Benefits for a longer Inpatient Stay if it is recommended by the Physician after conferring with the patient.

17. Infertility Services

Services for the treatment of infertility when provided by or under the direction of a Physician.

For the purpose of this benefit, infertility is defined as the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

Coverage must be provided for the expense for the diagnosis and treatment of infertility, including but not limited to:

- Ovulation induction.
- Intrauterine insemination.
- In-vitro fertilization.
- Uterine embryo lavage.
- Embryo transfer.
- Gamete intra-fallopian transfer (GIFT).
- Zygote intra-fallopian transfer (ZIFT).
- Low tubal ovum transfer.

Benefits for infertility include but are not limited to the following:

- Ovulation induction is limited to a maximum benefit of four cycles;
- Intrauterine insemination is limited to a maximum benefit of three cycles;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to a maximum of two cycles, with no more than two embryo implantations per cycle;
- IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful;

Covered Health Care Services must be performed at facilities that conform to the standards of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

18. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Additional screenings and services to monitor for breast cancer and other gynecological cancers may be considered preventive care services under state law. When applicable, They are covered with no Copayments or Coinsurance, however your Deductible may apply.
- These may be available to you, if you are believed to be at an increased risk due to:
 - A family history, or
 - A prior personal history of breast, ovarian, or certain related cancers, or
 - If the treatment of a childhood cancer has increased your risk of breast cancer, or

- A positive genetic test for gene variants that increase your risk to certain cancers, or
- Other indications as determined by the insured's physician, advanced practice registered nurse, physician assistant, certified nurse midwife or other medical provider.
- Requirements for each screening or service may vary and may be subject to Medical Necessity review.
- Diagnostic and screenings services may include, but may not be limited to:
- Mammograms, including mammograms provided by Breast Tomosynthesis.
- Comprehensive Ultrasound screening of an entire breast or breasts [if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
- Magnetic Resonance Imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.
- Mastectomies intended to prevent disease (prophylactic mastectomy).
- Genetic Testing.
- Routine screening procedures and surveillance tests for ovarian cancer.
- 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*.)
- Prostate Specific Antigen (PSA) tests to screen for prostate cancer for men who are symptomatic or whose biological father or brother has been diagnosed with prostate cancer and for all men fifty years of age or older. The treatment of prostate cancer is covered provided such treatment is medically necessary and in accordance with guidelines established by the *National Comprehensive Cancer Network*, the *American Cancer Society* or the *American Society of Clinical Oncology*.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

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*.

19. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services including radiologists, anesthesiologists and pathologists.

20. Medical Supplies

Benefits for medical supplies for Covered Health Care Services required for the treatment of Sickness or Injury. This includes maintenance supplies, such as ostomy supplies.

Benefits for diabetic supplies are described under *Diabetes Services*. Benefits for supplies associated with DME are described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

21. Mental Health Care Services

Mental Health Care Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Two wellness exams per year conducted by a licensed mental health professional or primary care provider, these exams will be conducted at no cost to the member, (no Coinsurance, Copayments, or deductibles), and Prior Authorization is not required for these 2 exams.

Benefits include the following levels of care:

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.
- Intensive, home-based or evidence-based services designed to address specific mental or nervous conditions in a child or adolescent while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's, adolescent's, and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.
- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities.
- Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician, or advanced practice registered nurse (APRN) and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:

- The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, advanced practice registered nurse (APRN), psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
- Extended day treatment programs.

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 include the following levels of care:

- Inpatient Treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA).

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care.

22. Oral Surgery

The following limited dental and oral surgical procedures in either an inpatient or outpatient setting:

- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Removal of cysts related to teeth is not covered.

- Surgical and nonsurgical medical procedures for temporomandibular joint (TMJ) disorders and orthognathic surgery.

23. Orthoptic Exercises and Corneal Topographic Procedures

Orthoptic exercises for the treatment of the following conditions:

- Amblyopia for Covered Persons up to age 19. Treatment includes patching and penalization therapies.
- Convergence insufficiency.

Corneal topographic procedures for the treatment of certain conditions.

24. Ostomy Supplies

Benefits for Medically Necessary appliances and supplies relating to an ostomy include, but are not limited to, the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.
- Collection devices

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

25. Pharmaceutical Products – Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their 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 may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card..

Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Co-payment and/or Co-insurance, you may receive Pharmaceutical Products 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 order or refill and/or the amount dispensed per month's supply.

You may find out whether a Pharmaceutical Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Certain Specialty Pharmaceutical Products are eligible for coupons or offers 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 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 Specialty Pharmaceutical Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Schedule of Benefits*.

26. 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 allergy testing and treatment, including routine allergy injections.

Immunization coverage and 20 minute immunization consultation between Member and the Physician.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient*.

27. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

If discharge occurs earlier than these timeframes, we will pay Benefits for a follow-up visit within 48 hours of discharge and an additional follow-up visit within seven days of discharge.

Follow-up services will include, but not limited to, the following:

- Physical assessment of the newborn.
- Parent education.
- Assistance and training in breast or bottle feeding, which is covered as long as Medically Necessary and is not limited to the follow-up visit within 48 hours of discharge or the additional follow-up visit within 7 days of discharge.
- Assessment of the home support system.
- Performance of any Medically Necessary and appropriate clinical tests.

Follow-up services must be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations. Follow-up services must be provided by a qualified health care personnel trained in post-partum maternal and newborn pediatric care.

28. 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).

29. 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*.
- 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. 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.

30. 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, Medical Equipment and Prosthetics*.

31. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be Medically Necessary by the Physician.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of

complications, 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.

32. 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, advanced practice registered nurse or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

33. Second and Third Opinions

Second and third opinions requested by you or by us.

At your request:

- If you disagree with a Network provider's recommended course of treatment, you may request that another provider render a second opinion.
- If the first and second opinions do not agree, we will designate a Network provider to render a third opinion at no cost to you.
- After reviewing the third opinion, we will cover the Covered Health Care Services supported by a majority of the providers reviewing your case.
- If the first opinion concerns a diagnosis of cancer (either negative or positive) or treatment for cancer, you may obtain a second opinion from an out-of-Network provider on a Network basis.

At our request:

- We reserve the right to require a second opinion for any surgical procedure.

- If a second surgical opinion is required, we will refer you to a Network provider for the second opinion at no cost to you.
- In the event that the first and second surgical opinions differ, a third opinion will be required. We will designate another Network provider for a third opinion at no cost to you.
- The third opinion will determine whether the procedure will be covered. The providers who render the second or third opinion are not eligible to perform the procedure.

34. 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 including radiologists, anesthesiologists and pathologists.

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.

35. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Two wellness exams per year conducted by a licensed mental health professional or primary care provider, these exams will be conducted at no cost to the member, (no Coinsurance, Copayments, or deductibles), and Prior Authorization is not required for these 2 exams.

- General inpatient hospitalization, including in state-operated facilities.
- Medically necessary acute treatment services and medically necessary clinical stabilization services.
- General hospital outpatient services, including at state-operated facilities.
- Psychiatric inpatient hospitalization, including in state-operated facilities.
- Psychiatric outpatient hospital services, including at state-operated facilities.
- Intensive outpatient services, including at state-operated facilities.
- Partial hospitalization, including at state-operated facilities.
- Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders.

- Intensive, home-based services designed to address specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function.
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.
- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders and delinquency.
- Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency.
- Other home-based therapeutic interventions for children.
- Chemical maintenance treatment.
- Nonhospital inpatient detoxification.
- Medically monitored detoxification.
- Ambulatory detoxification.
- Inpatient services at psychiatric residential treatment facilities. Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician and approved by the Mental Health/Substance Use Disorder Designee. For the purpose of this benefit, all of the following criteria must be met:
 - The Covered Person has a serious mental or nervous condition which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior; and
 - The Covered Person, upon an assessment by a Physician, psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
 - Extended day treatment programs.
 - Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities.
 - Observation beds in acute hospital settings.
 - Psychological and neuropsychological testing conducted by an appropriately licensed health care provider.
 - Trauma screening conducted by a licensed behavioral health professional.
 - Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional.
 - Substance use screening conducted by a licensed behavioral health professional.

We will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it will be covered on a Semi-private Room basis.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care.

36. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Sterilization. Note: Sterilization for women is not subject to cost share.
- Physician services including radiologists, anesthesiologists and pathologists.
- Please refer to our provider directory located on our website at www.myuhc.com for assistance with identifying the different types of facilities.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Included under this section is coverage for colorectal cancer screenings, including, but not limited to annual fecal occult blood test, colonoscopy and flexible sigmoidoscopy/radiologicimaging in accordance with the recommendations established by the *American Cancer Society*. There is no cost share when more than 1 colonoscopy is ordered in a policy year.

37. Termination of Pregnancy

Therapeutic abortions and abortions in the case of rape, incest or fetal malformation. Elective abortions are covered. Benefits are limited as stated in the *Schedule of Benefits*.

38. Telehealth Services

Telehealth services are covered when services are received for the diagnosis, prevention, treatment, cure or relief of a physical or mental health conditions, illness, injury or disease. These services are covered to the same extent that the same services would be covered if received during a face to face consultation. The cost share for Telehealth services will be based on the type of provider who rendered the services (Primary Care Physician, Specialist, registered nurse or advanced practice registered nurse), as outlined in your Summary of Benefits. If these services are received from a network Telehealth provider, they will be covered at the network level of benefits, and if received from an Out-of-Network provider, they will be covered at the Out-of-Network level of benefits.

Physicians and APRNs to certify a qualifying patient's use of medical marijuana and provide follow -up care via telehealth.

For purposes of this Benefit, "Telehealth" means the mode of delivering health care or other health care services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a covered member's physical and mental health and includes:

- Interaction between the patient at an originating site and the Telehealth provider at a distant site, and
 - Synchronous interactions, asynchronous store and forward transfers or remote monitoring.
- Telehealth does not include the use of facsimile, texting or electronic mail.

39. Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

Non-surgical treatment including, but not limited to, appliances, behavior modification, physiotherapy and prosthodontic therapy is not covered.

40. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

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 including anesthesiologists, pathologists and radiologists.
- Sleep studies.

Two wellness exams per year conducted by a licensed mental health professional or primary care provider, these exams will be conducted at no cost to the member, (no Coinsurance, Copayments, or deductibles), and Prior Authorization is not required for these 2 exams.

41. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.

- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs 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.

Human leukocyte antigen testing or histocompatibility locus antigen testing for A, B and DR antigens (testing to determine the compatibility for bone marrow transplants). The bone marrow testing must be performed at a facility certified under the federal Clinical Laboratory Improvement Act and accredited by the American Society for Histocompatibility and Immunogenetics. Enrollees must register for the National Marrow Donor Program when being tested.

We have specific guidelines regarding Benefits for transplant services. Call us at the telephone number on your ID card for information about these guidelines.

- Transportation, Lodging and Meal Expenses for Transplants
- Expenses for transplantation, lodging, and meals for the transplant recipient and his or her companion are reimbursable per transplant episode.
- A "transplant episode" is the time from the initial evaluation for the transplant until 90 days after the recipient is discharged from the transplant facility or until the recipient is cleared to return home, whichever is sooner.
- The transplant facility must be more than 300 miles from the transplant recipient's home for this reimbursement to apply.
- Transportation costs incurred for travel to and from the transplant facility for the transplant recipient and one other individual accompanying the recipient are covered.
- If air transportation is chosen, coverage includes round trip transportation for the transplant recipient and one other individual accompanying the recipient up to two round trips per person.
- If travel occurs via automobile, mileage will be reimbursed based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was undertaken for a maximum of one round trip from the transplant recipient's home to the transplant facility.
- Transportation, lodging and meal receipts must be submitted to us at the appropriate address listed in the information you receive from us when authorizing this reimbursement.
- There is no coverage for the following expenses:
 - Any expenses for anyone other than the transplant recipient and the designated traveling companion.

- Any expenses other than the transportation, lodging and meals described in this provision.
- Local transportation costs while at the transplant facility.
- Rental car costs.

42. 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*.

43. Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email or fax, or for services that occur within medical facilities.

44. Wigs

Wigs and other scalp hair prosthesis for a Covered Person who suffers hair loss as a result of chemotherapy when prescribed by a licensed oncologist.

Additional Benefits Required By Connecticut Law

45. Craniofacial Disorders

Benefits for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Covered Persons eighteen years of age or younger when prescribed by a craniofacial team recognized by the *American Cleft Palate Craniofacial Association*. This does not provide coverage for cosmetic surgery.

46. Dental Services

Surgery, general anesthesia, nursing and associated Hospital or Alternative Facility services provided in conjunction with inpatient, outpatient or one-day dental services when the dentist or oral surgeon and the Physician determine that the services are Medically Necessary for the treatment of either of the following types of patient:

- A person who is determined by a dentist, in conjunction with a Physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- A person who has a developmental disability, as determined by a Physician who specializes in primary care that places the person at serious risk.

47. Developmental Needs of Children & Youth with Cancer

- Neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in children due to chemotherapy or radiation treatment.

48. Early Intervention Services

- Coverage for early intervention services provided as part of an individualized family services plan as defined by Connecticut law for a child from birth until the child's third birthday.
- Turns three years of age on or after May first and not later than the first day of the next school year commencing July first.
- Early intervention services are not subject to co-insurance, co-payments, deductibles or other out-of-pocket expenses, regardless of whether the provider is a Network or Out-of-Network provider.

49. Lyme Disease Services

Coverage for Lyme disease treatment, including but not limited to up to 30 days of intravenous antibiotic therapy and/or sixty days of oral antibiotic therapy and further treatment will be provided if recommended.

50. Medical Foods

Coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the treatment of inherited metabolic diseases and are administered under the direction of a Physician.

In addition, coverage must be provided for specialized formulas when they are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician.

Inherited metabolic diseases - a disease for which newborn screening is required under section 19a-55 of the general statutes of Connecticut and cystic fibrosis.

Amino acid modified preparation - a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Specialized formula - a nutritional formula for children up to the age of twelve years of age that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

51. Nutritional Counseling

Nutritional Counseling is a Covered Health Care Service for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity. In addition, the services must be prescribed by a licensed health care professional and provided by a certified, registered or licensed health care professional in a physician's office or outpatient facility.

52. Pain Management

Covered Health Care Services received by a pain management specialist for pain treatment which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

53. Wound Care Supplies

Wound care supplies for the treatment of epidermolysis bullosa when administered under the direction of a Physician. Epidermolysis bullosa is a rare inherited genetic disorder caused by a mutation in the keratin gene. The disorder is characterized by the presence of extremely fragile skin and recurrent blister formation, resulting from minor mechanical friction or trauma. The resulting wounds require continuous treatment.

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. This exclusion does not apply to acupressure and acupuncture services for which Benefits are available as described under *Pain Management* in *Section 1: Covered Health Care Services*.
2. Aromatherapy.
3. Hypnotism.
4. Rolfing.
5. Wilderness, adventure, camping, outdoor, or other similar programs.
6. 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). This exclusion does not apply to services for which Benefits are provided as described under in *Section 1: Covered Health Care Services*.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Removal of teeth (including wisdom teeth).
- 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*.

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.
6. Removal of cysts related to teeth.

C. Devices, Appliances, Medical Equipment 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.
 8. Powered and non-powered exoskeleton devices.
 9. 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*.
 10. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
 11. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to medications covered under *Section 1: Covered Health Care Services*.
2. Self-administered or self-infused medications. This exclusion does not apply to medications covered under *Diabetes Services* in *Section 1: Covered Health Care Services*. 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.
3. Over-the-counter drugs and treatments.
4. Growth hormone therapy.
5. 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*.
6. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
7. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological

Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

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 or preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Care Services.

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. Mental Health Care Services

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

I. 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.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - 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, escalators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers or water purifiers.
 - Jacuzzis.
 - Mattresses or waterbeds.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Safety equipment.
 - Saunas.
 - Stair lifts and stair glides.

- Strollers.
- Swimming pools.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Sclerotherapy treatment of veins.
 - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

The exception to this is the removal of a breast implant which was implanted on or prior to July 1, 1994, without regard to the purpose of such implantation.
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 control. All services, supplies, programs and surgical procedures for the purpose of weight control, except surgical procedures that are Medically Necessary for the treatment of morbid obesity.
6. Wigs, except as required for hair loss due to chemotherapy as described in *Section 1: Covered Health Care Services*.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
8. Biofeedback, except as required for treatment of Urinary Incontinence.
9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; and dental restorations. Medically Necessary TMJ services for surgical medical and dental should be covered.
10. Non-surgical treatment of obesity.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
13. Intracellular micronutrient testing.
14. Cellular and Gene Therapy services not received from a Designated Provider.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal 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.
4. No-show charges. If a provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

N. Reproduction

1. The following infertility treatment-related services:

- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, testicular tissue, and ovarian tissue, unless harvesting eggs for surrogate is a covered expense if harvested from the member.
 - Donor services.
2. The following services related to a Gestational Carrier or Surrogate:
- All costs related to reproductive techniques including:
 - ◆ Assisted Reproductive Technology (ART).
 - ◆ Artificial insemination.
 - ◆ Intrauterine insemination.
 - ◆ Obtaining and transferring embryo(s).
 - ◆ Preimplantation Genetic Testing (PGT) and related services.

The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care 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. The reversal of voluntary sterilization.
5. Elective fertility preservation.
6. In vitro fertilization that is not used as an Assisted Reproductive Technology for the treatment of infertility. 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*.

O. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Except as otherwise provided under Conn. Gen. Stat. Section 38a – 527, health care services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements.

Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

P. Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other 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* or 2) transportation, lodging and meal expense for which Benefits are provided as described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain, unless such treatment is Medically Necessary and has been ordered by a pain management specialist.
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.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
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. 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.
5. 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.

Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.

- Described as a Covered Health Care Service in this Certificate under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
 3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
 7. Follow-up care provided in a Hospital Emergency room.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Blood, blood plasma, blood derivatives and synthetic blood. This exclusion does not apply to services that are covered in *Section 1: Covered Health Care Services*. Apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not covered.
 10. Routine harvesting and storage of stem cells from newborn cord blood.
 11. Autopsy.
 12. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
 13. Services or supplies that have been fraudulently obtained.
 14. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

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.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth for the first 61 days even when no dependent coverage is purchased.
- Legal adoption.
- Placement for adoption.
- Marriage or Civil Union.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the event.

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.

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 birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days (61 days for newborns) of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day 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. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health 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). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

If the Group terminates you for any reason other than a layoff or relocation or closing of a covered establishment, or if you voluntarily leave your place of employment, the Group may decide to not pay the premium for you and your Enrolled Dependents after the date of termination. If the Group makes this election, the Group must:

- Notify us within 72 hours of the termination of your employment so that we may process the request; and
- Notify you of the termination of health care coverage
- When the Group has exercised this election and has provided the required notices, your coverage will terminate three calendar days after termination of employment. It is the Group's responsibility to remit to you your portion of the credited premium.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." The Group can provide you with specific information on which of these dates apply.

Dependent coverage will end on the policy anniversary date after the Dependent reaches age 26.

- **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. The Group can provide you with specific information on which of these dates apply.

- **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. The Group can provide you with specific information on which of these dates apply.

This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 31 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.

During the first two years the Policy is in effect, 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.

Notice of Termination

The Group must furnish each Subscriber notice of the termination of this Policy. The notice will be mailed or delivered to the Subscriber not less than fifteen days preceding the effective date of the termination. The notice is not required if the Group replaces this Policy with another group health insurance policy without interruption of coverage. If the Group fails to furnish the notice, the Group will be liable for benefits to the same extent as we would have been liable if the Policy had not been terminated.

Coverage for a Disabled Dependent Child

Coverage for an Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy ends.

Continuation 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 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 to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation Coverage under State Law

Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage ends and if your coverage ends under the Policy as described below. This continuation applies to you if the Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Groups that are not subject to the terms of *COBRA*. You should call your Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.
- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.

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 180 days 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.

If a provider of ambulance services complies with the statutory provision for direct payment and that provider has not been paid from any other source, Allowed Amounts due to that provider will be paid directly to that provider instead of being paid to the Subscriber.

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.

If your Benefit plan includes an *Outpatient Prescription Drug Rider* and you need to file a claim, your claim should be submitted to:

Optum RX
PO Box 650629
Dallas, TX 75265-0629

Payment of Benefits

When you receive Covered Health Care Services from an Out-of-Network provider, we may reimburse you directly, less any applicable Annual Deductible, Co-payment and any amount that exceeds Allowed Amounts and you will then be responsible for reimbursing the Out-of-Network provider. The reimbursement will be based on the definition of Allowed Amounts as described under *Section 9: Defined Terms*. You may assign your right to reimbursement under this Certificate to a dentist or oral surgeon provided (1) the dentist or oral surgeon does not charge you more than what the dentist/oral surgeon would charge an uninsured patient for the same services, and (2) the dentist or oral surgeon allows Us to review medical records, with at least 48 hours notice, during regular business hours. For all other types of providers, you may not assign your right to reimbursement under this Certificate to an Out-of-Network provider without our consent. We may, however, in our discretion, pay an Out-of-Network provider directly for services rendered to you.

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.

When claims are received via paper format, we will pay Benefits within 60 days after we receive your request for payment that includes all required information. When claims are received via electronic format, we will pay Benefits within 20 days after we receive your request for payment that includes all required information.

In a case where our obligation to pay a claim is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the Benefits covered under the Policy, or the manner in which services were accessed or provided, we will pay any undisputed portion of the claim in accordance with the 60/20 day time period and notify you in writing within: 1) 30 days of the receipt of the paper claim; or 2) 10 days of receipt of an electronic claim:

- that we are not obligated to pay the claim, stating the specific reasons why we are not liable; or
- to request all additional information needed to determine liability to pay the claim.

Upon receipt of the required information we will process the claim.

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. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

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.

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 can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- 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.

This section describes the process for appealing a (1) utilization review (UR) decision or (2) a benefit, network or administrative decision. The process you will need to use depends upon the type of issue you are trying to resolve. Please read the information in the section carefully, as it describes what the different review procedures are and when and how to use them. If you are still not sure of the process to follow, contact us at the telephone number shown on your ID card.

Copies of these procedures are available in many languages and can be forwarded to you subject to availability. We can also arrange to have an independent interpreter available, however our ability to provide this service depends on the availability of the interpreter. We may need to arrange to call you at a

time when an interpreter is available. Additionally, you always have the right to designate a representative during this process.

Authorized Representatives

You have the right to use these procedures. It is your responsibility to begin a complaint or appeal within the timeframes set forth in this *Certificate*.

You may designate a person to act on your behalf, including your healthcare provider ("authorized representative"). For appeals of benefit determinations concerning urgent care, we are required to allow your healthcare provider, with knowledge of your condition, to act as your authorized representative without your written consent. A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without care or treatment that is the subject of the determination.

For all other circumstances, to authorize a representative to act on your behalf, you must provide us with written consent at the time your complaint or appeal is submitted. Because your medical records are privileged and confidential, and we want to ensure that you wish to appeal, you must submit an original signed written consent. Covered Person(s) who are 18 years of age or older, including a member's spouse or children, will need to provide their own signed written consent. If the member is a minor, a written consent must be signed by the member's parent or guardian.

Your authorized representative will only be authorized to act on your behalf and is required to comply with all of the conditions of your Certificate that would apply to you when you begin any appeal or complaint. Your authorized representative is not entitled to obtain any benefits or rights under your Certificate.

Utilization Review (UR) Appeals

UR will happen whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. The utilization review appeals process should be used after you have received an initial adverse UR determination and you do not agree with our decision. All appeals are subject to a review by us to evaluate the medical necessity of the services. You may use this process to appeal adverse determinations relating to all UR determinations, regardless of whether the services requested by you or your authorized representative have not yet been rendered (pre-service), are currently being rendered (concurrent) or have already been rendered (post-service).

Please note: This UR appeals process should not be used for appeals relating to benefit, network or administrative issues.

UR appeals must be within 180 days from receipt of an adverse determination (i.e., receipt of the determination notice). A decision may be rendered within the standard timeframes or may be expedited as described in this section.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Unless we have already issued a written determination, we will use our best efforts to provide written acknowledgement of the receipt of your appeal within 5 business days, but in no event later than 15 calendar days. Our decision to either uphold or reverse the adverse determination will be made and communicated to you as follows:

- Request for service (pre-service): Within 30 calendar days of our receipt of the appeal.

- Concurrent services for a member in an ongoing course of treatment (concurrent): Within 30 calendar days of our receipt of the appeal. In this instance, treatment will be continued without liability while your appeal is being reviewed.
- Coverage for services rendered (post-service): Within 60 calendar days of our receipt of the appeal.
- If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.
- This will be our final adverse determination. If you are not satisfied with our decision, you have the option of filing an external appeal (explained in the section below, "External Appeals.")

Expedited/Urgent Utilization Review (UR) Appeals

You can expedite your UR appeal when:

- You receive an adverse determination involving continued or extended health care services, procedures or treatments or additional services while you are undergoing a course of continued treatment (concurrent) prescribed by a health care provider; or
- The timeframes of the non-expedited UR appeal process would seriously jeopardize your life, health or ability to regain maximum function; or
- In the opinion of a Physician with knowledge of the health condition, the timeframes of the non-expedited UR appeal process would cause you severe pain that cannot be managed without the care of treatment that was requested; or
- Your Physician believes an immediate appeal is necessary because the timeframes of the non-expedited UR appeal process would significantly increase the risk to your health; or
- For Mental Health and Substance-Related and Addictive Disorders, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.
- You have two available options for expedited reviews. **These options are not available for Covered Health Care Services that have already been rendered (post-service).**

1. Internal Expedited UR Appeal: This process includes procedures to facilitate a timely resolution of the appeal including, but not limited to, the sharing of information between your provider and us by telephone or facsimile. We will provide reasonable access to our clinical peer reviewer within one business day of receiving notice of an expedited UR appeal.

A decision will be rendered and communicated for an internal expedited UR appeal within the following timeframes:

- 24 hours from our receipt of the appeal when the service being appealed is for Substance-Related and Addictive Disorders or co-occurring mental disorder, and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the Covered Person requiring an inpatient setting in connection with a Mental Illness.
- Forty-eight hours or seventy-two hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend from our receipt of the appeal for all other types of services.

If you are not satisfied with the outcome of the expedited UR appeal, you may further appeal through the external appeal process. If we do not make a determination within forty-eight hours or seventy-two after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend, the adverse determination will be reversed. The notice of an appeal determination will include the reasons for the determination. If the adverse determination is upheld on appeal, the notice will include the specific

reason(s) and clinical rationale used to render the determination, a reference to the specific health benefit plan provisions on which the decision is based, a statement that you may receive from us, upon request and free of charge, reasonable access to and copies of all relevant documents. We will also include a notice of your right to begin an external appeal. A description of each process and associated timeframes will be included. If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.

2. External Expedited Appeal: You also have the option to seek review by an independent review organization (IRO) in Emergency or life-threatening circumstances. You may make a request to the Commissioner of Insurance for an expedited external appeal without first completing the internal appeals process if:

- The timeframe for completion of an expedited internal appeal may cause or exacerbate an Emergency or life-threatening situation; or
- For a Mental Health Care and Substance-Related and Addictive Disorders, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a Covered Person from requiring an inpatient setting; and
- You, or your provider acting on your behalf with your consent, have filed a request for expedited internal review.

If you choose this option, you must submit the appeal by contacting the Connecticut Insurance Department at P.O. Box 816, Hartford, CT 06142-0816 (telephone number: 860-297-3910). For more information on how to file an expedited external appeal, refer to External UR Appeals below.

Office of the Healthcare Advocate and the Division of Consumer Affairs

If we deny a requested service on the basis that the service is not Medically Necessary or because it is a Certificate exclusion and you believe you have been given erroneous information, you have the right to contact either *Connecticut's Office of the Healthcare Advocate* or the *Division of Consumer Affairs* for assistance. You may contact them at the address listed below:

State of Connecticut

Office of the Healthcare Advocate

P.O. Box 1543

Hartford, CT 06114

Telephone: 1-866-466-4446

E-mail: Healthcare.advocate@ct.gov

Consumer Affairs Division

P.O. Box 816

Hartford, CT 06142-0816

Telephone: 1-800-203-3447

E-mail: cid.ca@ct.gov

External UR Appeals

Under certain circumstances, you or, with your consent, your authorized representative or provider acting on your behalf, have a right to file an external appeal or expedited external appeal for the denial of coverage for services based on lack of Medically Necessary criteria or because the service is

Experimental or Investigational for a particular medical condition. Benefit or administrative determinations are not eligible for external appeal; only utilization review issues are eligible for external appeal.

You or your authorized representative have the right to request an external UR appeal in the following situations:

- The service, procedure or treatment must otherwise be a Covered Health Care Service under this *Certificate*; and
- You must have received a final adverse determination through the UR appeals review, with a denial based on lack of Medical Necessity criteria or Experimental or Investigational Service(s) treatment UNLESS it is determined that the timeframe for completion of an internal appeal may cause or exacerbate an Emergency or life threatening situation. In an Emergency or life-threatening situation, you or your authorized provider acting on your behalf with your consent would not need to complete the internal UR appeal in order to file for an external appeal.

How to File an External Appeal

To file an expedited external appeal, you can submit an application with the Connecticut Insurance Department immediately following receipt of our initial adverse determination or appeal determination.

If the expedited external appeal is not accepted on an expedited basis, and you have not previously completed the internal UR appeal process, you may resume the internal appeal process until all internal appeals are exhausted. You may then file for a standard external appeal within 120 days following receipt of the final denial letter.

If the internal appeals were previously exhausted, your rejected expedited appeal will automatically be eligible for consideration for standard external appeal. You are not required to submit a new application.

Remember: You may not file an expedited external review for services which have already been provided (post-service).

To file a non-expedited external appeal, you have 120 days to begin the appeal through the State of Connecticut Insurance Department after you have completed the internal UR appeal or after We and you both agree to waive the internal appeal process

Requests for external appeals and expedited external appeals must be in writing on an external appeal application form. The application form will include instructions on how to complete and submit the form to the Commissioner. You or your authorized representative (and Provider, if applicable) must release all pertinent medical information concerning your medical condition and request for services. You may contact Connecticut's Insurance Department at the following address or telephone number:

Connecticut Insurance Department

PO Box 816

Hartford, CT 06142-0816

Attn: Utilization Review Nurse Coordinator

(860) 297-3910

For Overnight delivery only, please send Your application for External Review to:

State of Connecticut Insurance Department

153 Market Street

P.O. Box 816

Hartford, CT 06142-0816

860-297-3910

The following items must be included in your Appeal. Your Appeal will be rejected if all of these items are not included:

- A completed "request for External Appeal" form.
- An authorization form allowing us and your health care professional to release your medical information to the independent review organization.
- Evidence of being an enrollee of the plan (photocopy of your insurance card).
- Copies of all correspondence from us.
- A copy of the final determination letter indicating that all internal appeal mechanisms have been exhausted.
- A copy of your policy or certificate of coverage.

In addition to the required items outlined above, you may also submit any additional information relevant to your condition.

Following receipt of the request for external appeal or expedited external appeal, the covered person or the covered persons authorized representative has filed and will forward the appeal to us so that we may confirm that your appeal is complete and satisfies the conditions listed below. We will complete this review within 5 business days for an external review request or within 1 day for an expedited external review request.

1. You are or were a member of the plan at the time of the event that is subject of the adverse determination.
2. The service in question reasonably appears to be a covered service under the Certificate but was denied because it does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
3. The service in question reasonably appears to be a covered Service under the Certificate but was denied because it is experimental or investigational for a particular medical condition, is not explicitly listed as an excluded benefit under your health benefit plan and your treating health care professional has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving your medical condition;
 - Standard health care services are not medically appropriate for you.
 - There is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment.

In addition, your treating health care professional:

- recommended a health care service or treatment that he/she certifies, in writing, is likely to be more beneficial to you, in his/her opinion, than any available standard health care services or treatments; or
 - Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat your condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the denied health care service or treatment is likely to be more beneficial to you than any available standard health care services or treatments.
4. You have completed both at least the First Level Appeal process;
 5. You have provided all of the required information

Once we have completed our review, we will notify you, your authorized representative (if appropriate) and the Insurance Commissioner whether the appeal is complete and eligible for external review. We will communicate our findings in writing within 1 business day for an external appeal or on the day the review is completed for an expedited external appeal. If your appeal is not complete, the notice will include what

information or materials are missing. If your appeal is not eligible, the notice will include the reason(s) it is not eligible. In either instance, you may appeal this determination to the Insurance Commissioner.

If the external review or the expedited external review is accepted, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the health carrier shall include in such notice a statement that the covered person or the covered person's authorized representative may submit, not later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, additional information in writing to the assigned independent review organization that such organization shall consider when conducting the external review, and (ii) where and how such additional information is to be submitted. If additional information is submitted later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information

We will forward the medical and treatment plan records we relied upon in making our determination to the Independent Review Organization. If the documentation represents a material change from the documentation upon which we based our adverse determination or denial, we will have the opportunity to consider the documentation and amend or confirm our adverse determination or denial. This review will not delay or terminate the external review.

The Independent Review Organization will make a determination with regard to the appeal within the following timeframes:

- External Reviews: within 45 days after assignment from the Commissioner
- External Review involving an experimental or investigational treatment: within 20 days after assignment from the Commissioner
- Expedited External Reviews: as expeditiously as your condition requires, but not later than:
 - 24 hours after assignment from the Commissioner when the service being appealed is for Substance - Related and Addictive Disorders or co-occurring mental disorder; and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder.
 - 48 hours or seventy-two hours after we receive the request if any portion of the forty-eight hour period falls on a weekend from our receipt of the appeal after assignment from the Commissioner for all other types of services.

Expedited External Reviews involving an experimental or investigational treatment: as expeditiously as your conditions requires, but not later than one business day after receiving such notice for an external review or one calendar day after receiving such notice for an expedited external review.

Upon completion of the review, the Independent Review Organization will communicate it's decision in writing to you, your authorized representative (if appropriate), the Commissioner and to us. If the decision is to reverse or revise our initial or final adverse determination, we will immediately approve the coverage, subject to the terms and conditions of this Certificate. The decision will be binding.

Benefit/Administrative Appeals

The benefit/administrative appeals process is used after you have received an initial adverse determination concerning a claim for benefits or an administrative issue. Benefit issues include, but are not limited to: denials based on benefit exclusions or limitations and claims payment disputes. Administrative issues would include issues such as access to providers, eligibility or enrollment issues.

Please Note: Benefit and administrative issues do not include determinations concerning the medical necessity of covered services. If we have denied your claims or request for services because we believe

the services are not medically necessary, do not use the process outlined in this section. Please refer to the above section, Utilization Review (UR) Appeals.

While a UR appeal may be filed by telephone or in writing, we strongly recommend that you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send any documentation/information already requested by us (if not previously submitted) and any additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Within 3 business days of receipt of your appeal, we will send you a notice informing you of your right to submit to us any additional written material you would like us to consider as part of our review. The notice will also provide the address, telephone number and the name of the Department handling your appeal.

Benefit/administrative appeals must begin by you or your authorized representative within 180 days from receipt of an adverse determination (i.e., an Explanation of Benefits, Denial Notice) or, for other issues, from the date when you became aware of the issue that begin the appeal.

We will provide you or your authorized representative or your provider with our written decision (by mail or electronic means) and the detailed reasons for our decision including clinical rationale (if applicable) and references to any specific plan provisions on which our decision was based within 20 business days of receipt of your appeal. This will be our final position.

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.

Within 3 business days of receipt of your appeal, we will send you a notice informing you of your right to submit to us any additional written material you would like us to consider as part of our review. The notice will also provide the address, telephone number and the name of the department handling your appeal.

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 and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, (other than long-term care contracts under the LTC Partnership Program in Connecticut), 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; other than long-term care contracts under the LTC Partnership Program in Connecticut), 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.

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.

End Stage Renal Disease

When a member has end stage renal disease (ESRD) and she/he has enrolled for Medicare coverage, benefits are coordinated in accordance with the Medicare Secondary Payer Rules.

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.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.

- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- 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 your *Schedule of Benefits*.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-Oxford 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. We will pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

This section is subject to the decisions rendered in Section 6: Questions, Complaints and Appeals, as you always have the right to file a complaint or appeal.

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.

This section is subject to the decisions rendered in *Section 6: Questions, Complaints and Appeals*, as you always have the right to file a complaint or appeal.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subject to applicable law, we have the right to subrogation and reimbursement. 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 fully return to us 100% of any Benefits you receive for that Sickness or Injury. 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. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying 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.
 - Providing any relevant information requested by us.

- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any 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.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the

Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- 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.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful 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. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- 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.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- 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, 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 this happens, we will explain the problem to you, and you must return the overpayment to us. If the refund is due from you do not return the overpayment to us within 60 days after receiving notification from us, 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. However, we will not initiate overpayment recovery efforts more than 24 months after the original payment was made unless we have a reasonable belief of fraud or intentional misrepresentation.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Air Ambulance - medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in 42 CFR 414.605.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us or determined as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or the Recognized Amount when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Reproductive Technology (ART) - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).

- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Applied Behavior Analysis - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

Autism Spectrum Disorder - means "autism spectrum disorder" as set forth in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

Behavior Therapy - any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Connecticut Commissioner of Social Services, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with Autism Spectrum Disorder, that are:

- Provided to children less than twenty-one years of age; and
- Provided or supervised by any of the following:
 - a behavior analyst who is certified by the *Behavior Analyst Certification Board*,
 - a licensed Physician, or
 - a licensed psychologist.
 - Behavioral Therapy is considered to be supervised by a behavior analyst, licensed Physician or licensed psychologist when the supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provided for each ten hours of behavioral therapy provided by the supervised provider.
 - Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorders.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Clinical Peer - will be used to evaluate the clinical appropriateness of an adverse determination and for external review determinations. A clinical peer is a physician or other health care professional who:

- (A) holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
- (B) for an urgent care review concerning
 - A child or adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or a child or adolescent mental disorder, holds (1) a national board certification in child and adolescent psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or child and adolescent mental disorder, as applicable, or
 - An adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or an adult mental disorder, holds (1) a national board certification in psychiatry, or (2) a doctoral level psychology degree with training and clinical experience in the treatment of adult Substance - Related and Addictive Disorder Substance - Related and Addictive Disorder or adult mental disorders, as applicable.

Co-insurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Continuity of Care - If you are undergoing an active course of treatment when a provider leaves the network, you may be eligible for Continuity of Care. For purposes of Continuity of Care, the following definitions apply:

Active Course of Treatment:

- A Medically Necessary, ongoing course of treatment for a life-threatening condition; or
- A Medically Necessary, ongoing course of treatment for a serious condition; or
- Medically Necessary care provided during the second or third trimester of pregnancy; or
- A Medically Necessary, ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the covered person's condition or interfere with anticipated outcomes.
- **Life-Threatening Condition:** a disease or condition for which the likelihood of death is probable unless the course of such disease or condition is interrupted.
- **Serious Condition:** a disease or condition that requires complex ongoing care such as chemotherapy, radiation therapy or postoperative visits, which the Covered Person is currently receiving.
- **Treating Network Provider:** a Member's treating health care provider or a facility at which the Member is receiving treatment that is removed from or leaves a health carrier's network.
- If you receive notice from us that your Treating Network Provider is no longer in our Network, you may be able to continue to receive Covered Health Care Services from your former Network Provider on an in-network basis in the following instances:
- You are in your second or third trimester of pregnancy: You may receive Covered Health Care Services through delivery and any post-partum care directly related to the delivery.
- You are undergoing an active course of treatment: We may extend in-network coverage to the earliest of the following:
 - ◆ Termination of the course of treatment by you or your treating provider; or
 - ◆ 90 days after the treating provider is removed from or leaves the network, unless Our Medical Director determines that a longer period is necessary; or
 - ◆ The date that care is successfully transitioned to another network provider; or
 - ◆ The date the benefit limitations under the health benefit plan are met or exceeded; or
 - ◆ The date We determine care is no longer Medically Necessary.
 - ◆ Continuity of Care is available only if the provider agrees to continue to follow Our reimbursement rates, policies and procedures. If the provider so agrees, you will receive these Covered Health Care Services as if they are being provided by a network provider. You will only be responsible for the in-network cost share, which will be applied to the in-network deductible and Out-of-Pocket Limit, if applicable to your plan. Pregnancies that are affected by this provision are automatically covered on an in-network basis.

If the Treating Network Provider was terminated by Us due to quality of care, Continuity of Care is not available.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the policy anniversary date following the date the child reaches age 26.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

The Dependent age limit will be specified in your *Schedule of Benefits*, including if your Group has chosen a Dependent age above 26.

Designated Diagnostic Provider - a provider and/or facility that we have identified through our designation programs as a Designated Diagnostic Provider.

Designated Dispensing Entity - a pharmacy, provider, or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the 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.

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 in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use, except that coverage is provided for a drug which has been prescribed for treatment of certain types of cancer for which the drug has not been approved by the *FDA*, provided the drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following three established reference compendia: (1) *The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital's Pharmacist's American Hospital Formulary Service Drug Information (AHES-DI)*. However, there is no coverage for any drug which the *FDA* has determined to be contraindicated for the specific cancer for which the drug has been prescribed.

2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight. except that Benefits for a procedure, treatment or the use of any drug will not be denied as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase 3 clinical trial.
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.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - 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 - an agency or organization which meets all of the following:

- Is primarily engaged in and is federally certified as a home health agency and is duly licensed (if such licensing is required) by the appropriate licensing authority to provide nursing and other therapeutic services.
- Has their policy established by a professional group associated with the agency or organization, including at least one Physician and at least one registered nurse, to govern the services provided.
- Provides for full-time supervision of such services by a Physician or by an advanced practiced registered nurse.
- Maintains a complete medical record on each patient.
- Has an administrator.

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.

Individual Treatment Plan - a treatment plan prescribed by a Physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms 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, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), 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.

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, or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

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. In determining whether health care services are Medically Necessary, we reserve the right to consult a subject matter expert of our choice and apply physician relevant specialty society recommendations.

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.

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 *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service. "Mental or nervous conditions" does not include additional

conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service. "Mental or nervous conditions" does not include additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders.

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.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* Criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-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 - 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, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- *Group Application.*
- *Riders.*
- *Amendments.*

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT) - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount - the amount which Co-payment, Co-insurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1. An *All Payer Model Agreement* if adopted, or
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 if you have Benefits for Outpatient Prescription Drugs, while presented in Rider format, they 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.

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider and a third party vendor. When this program applies, the out-of-Network provider's billed charges will be discounted. Co-insurance and any applicable deductible would still apply to the reduced charge. Our policy provisions or administrative practices may supersede the scheduled rate. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.
- The median amount negotiated with Network providers for the same or similar service.

In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card for assistance with resolving that issue. Shared Savings Program providers are not Network providers and are not credentialed by us.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost, biotechnology drugs used to treat patients with certain illnesses.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *Diagnostic and Statistical Manual of 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.

Surprise Bill - A bill for health care services, other than emergency service or urgent crisis center services, received by an insured for services rendered by an out-of-network health care provider or out-of-network clinical laboratories, where such services were rendered by such out-of-network provider or out-of-network clinical laboratories, at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider or out-of-network clinical laboratories.

A "surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network or out-of-network clinical laboratories.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM)* Criteria and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Outpatient Prescription Drug Rider

Oxford Health Insurance, Inc.

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 Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *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*.



Junior Harewood
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, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to

dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, by contacting us at www.myuhc.com or the telephone number on your ID card.

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.

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.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at a Retail Network Pharmacy.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you must meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your *Certificate*, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may

access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at www.myuhc.com or the telephone number on your ID card.

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drugs* section of the *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.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

The *Outpatient Prescription Drugs* section of the *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 Drugs* section of the *Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drugs from a Retail Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail out-of-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drugs* section of the *Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drugs* section of the *Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
4. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to drugs for the treatment of a disabling or life-threatening chronic disease or cancer that have not been approved by the *Federal Food and Drug Administration* for that indication, if the drug has been prescribed for a Covered Person who has been diagnosed with a disabling or life-threatening chronic disease or cancer, provided the drug is recognized for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed in one of the following established reference compendia: (1) *The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USPDI)*; (2) *The American Medical Association's Drug Evaluations (AMADE)*; or (3) *The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI)*. This exception does not provide coverage for any experimental or investigational drugs or any drug which the *Federal Food and Drug Administration* has determined to be contraindicated for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws, subject to applicable law.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
11. Certain unit dose packaging or repackagers of Prescription Drug Products.

12. Medications used for cosmetic purposes, except for medications prescribed for gender identity reasons as outlined in your *Certificate of Coverage*. These medications require medical necessity review by Us.
13. 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, except that such review and approval of new Prescription Drug Products and/or new dosage forms will not be required for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in a substantially accepted peer-reviewed medical literature. The standard reference compendia are noted above under the Experimental, Investigational or Unproven Services Exclusion.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Certain Prescription Drug Products for tobacco cessation.
16. 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 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 either Tier 2 or Tier 3.)
17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
18. Growth hormone therapy. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
19. 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
20. Certain Prescription Drug Products that have not been prescribed by a Specialist.
21. A Prescription Drug Product that contains marijuana, including medical marijuana unless prescribed as treatment for pain management.
22. A Prescription Drug Product with either:
 - An approved biosimilar.
 - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

 - It is highly similar to a reference product (a biological Prescription Drug Product).
 - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
25. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

Infertility - not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

- One year, if you are a female under age 35.
- Six months, if you are a female age 35 or older.

In addition, in order to be eligible for Benefits, you must also:

- Be a female under age 44.
- Have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.

- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

Out-of-Pocket Drug Limit - the maximum amount you pay for covered Prescription Drug Products every year. The *Outpatient Prescription Drugs* section of the *Schedule of Benefits* will tell you how the Out-of-Pocket Drug Limit applies.

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*.
- 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.

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. The amount you pay for a prescription will be the lesser amount of the drug, you will not have to pay the applicable copayment if the drug cost is less.

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.
- Hypodermic needles or syringes
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
 - glucose meters, including continuous glucose monitors.
 - any medically necessary diabetic supplies.
- Topical dental preparations.

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.

Specialized Formula - A nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal *Food and Drug Administration* and is intended for use solely under medical supervision in the dietary management of specific diseases.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products include 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 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.

UnitedHealthcare Rewards Rider

Oxford Health Insurance, Inc.

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 Oxford Health Insurance, Inc. 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 wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the program, then you might qualify for an opportunity to earn the same reward by different means. You can call us at the telephone number listed on your ID card, and we will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health 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. |
| Active - Fitness | 30 minutes or more of activity as designated by the program or 10,000 or more steps per day | |
| Other Health-Related Actions and/or Activities | One or more actions and/or activities defined by us and aimed at the following: <ul style="list-style-type: none">• Health education;• Improving health; or | |

| | | |
|--|----------------------|--|
| | • Maintaining health | |
|--|----------------------|--|

You may access your actions and/or activity tracking and rewards on www.myuhc.com.

If you have not achieved any of the above daily activity targets, you may be eligible to earn a reward for synchronizing or otherwise providing your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

Rewards

Rewards listed above, when earned, will be credited to either a *Health Reimbursement Account (HRA)* or a *Health Savings Account (HSA)* or distributed in other reward types as applicable, administered by us.

Device

A device, which includes an application, approved by us is used to track actions and/or activities towards earning a reward. If you choose to use a non-compatible device, you may be eligible to earn a reward; however, the reward may be limited.



Junior Harewood
President

Sweat Equity Fitness Reimbursement Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides a description of the Sweat Equity Fitness Reimbursement 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 (Certificate)* in *Section 9: Defined Terms*.

When we use the words "we", "us", and "our" in this document, we are referring to Oxford Health Insurance, Inc.. When we use the words "you" and "your" we are referring to the Subscriber and Spouse and Enrolled Dependents.

Sweat Equity Fitness Reimbursement Program

The purpose of this fitness reimbursement program is to encourage you to take a more active role in managing your health and well-being.

We will provide partial reimbursement for eligible fees associated with certain exercise that promotes cardiovascular wellness as described below.

Exercise activity fees include costs you pay for exercise facility fees, or exercise facility and class membership fees, outdoor bike rentals, organized group exercise classes, individual fitness instruction, organized group physical event, such as a marathon but only if such fees are paid to facilities or organizations which maintain equipment and/or offer programs, which may include certain digital application-based exercise programs, that promote cardiovascular wellness and are available to the general public. You can call us at the telephone number on your ID card for the current list of any eligible digital application-based exercise programs.

Membership in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits, organized group exercise classes, sessions, bike rides or organized group physical events. We will not provide reimbursement for the purchase of equipment, clothing, vitamins or other items or services that may be offered by the facility or organization (e.g., massages, etc.).

In order to be eligible for reimbursement, you must:

- Be an active member of the facility or program, attend organized group classes at the exercise facility or organization, and
- Complete a combined total of 50 visits, organized group classes, sessions, bike rides or organized group physical events in a six-month period.

In order to obtain reimbursement, at the end of the six-month period, you must submit:

- A completed reimbursement form from the facility or program of your visits, sessions, and events. Each time you use the exercise facility, a facility representative must sign and date the reimbursement form; documentation of the visits, such a system-generated, dated accounting of your workout(s).
- A copy of your current facility bill(s), class or program bill which shows the fee paid for your class membership, workout visits, organized group classes, sessions, bike rides or organized group physical events.
- A copy of the brochure or website printout that outlines the services or programs the exercise facility, class, session or event offers.

Once we receive the completed reimbursement form; documentation of the visits and the facility, class, event, or program bill(s), the Subscriber will be reimbursed up to \$200 and each Enrolled Dependent will be reimbursed up to \$100 or the actual cost of the eligible facility, class, program, session, event or membership per six month period, whichever is less. If you are unable to meet a standard related to a health factor for reimbursement under this fitness reimbursement program, you might qualify for an opportunity to earn the same reward by different means. Call us at the number on your identification (ID card, and we will work with you and, if necessary, your Physician, to find another way for you to earn the same reward.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

Reimbursement must be requested within 120 days of the end of the six-month period. Reimbursement will be issued only after you have completed each six-month period even if 50 visits are completed sooner.

A handwritten signature in black ink, appearing to be 'JH', written in a cursive style.

Junior Harewood
President

Real Appeal Rider

Oxford Health Insurance, Inc.

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 13 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.



Junior Harewood
President

Domestic Partner Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides coverage for Domestic Partners.

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 the Certificate of Coverage (*Certificate*) in *Section 9: Defined Terms* and in this Rider below.

When we use the words "we", "us", and "our" in this document, we are referring Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Coverage for Domestic Partners

The provisions below replace the provision shown in the *Certificate* in order to add coverage for Domestic Partners when they are enrolled as Dependents of Subscribers.

Section 3: When Coverage Begins

The section titled Adding New Dependents in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 (61 days for newborns) of the event.

The section titled Special Enrollment Period in the Certificate, Section 3: When Coverage Begins, is replaced with the following:

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 birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 (61 days for newborns) days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day 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 9: Defined Terms

The definition of Dependent in the Certificate under Section 9: Defined Terms is replaced with the following:

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*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the policy anniversary date following the date the child reaches age 26.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

The following definitions of Domestic Partner and Domestic Partnership are added to the Certificate under Section 9: Defined Terms:

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 and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - They have a single dedicated relationship of at least 6 - 18 months.
 - They have joint ownership of a residence.
 - They have at least two of the following:

- ◆ A joint ownership of an automobile.
- ◆ A joint checking, bank or investment account.
- ◆ A joint credit account.
- ◆ A lease for a residence identifying both partners as tenants.
- ◆ A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

A handwritten signature in cursive script that reads "Jessica Paik".

Jessica Paik
President

Zero Cost Share Medications Addendum

Oxford Health Insurance, Inc.

As described in this addendum, certain Prescription Drug Products as described in the *Outpatient Prescription Drug Rider* and *Schedule of Benefits* are modified as stated below.

Because this addendum 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 (Certificate)* in *Section 9: Defined Terms*, in the *Outpatient Prescription Drug Rider* in *Section 3: Defined Terms*, and in this addendum below.

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

You are not responsible for paying any applicable deductible for Prescription Drug Products on the List of Zero Cost Share Medications unless required by state or federal law.

The following definition is added to *Section 3: Defined Terms* in the *Outpatient Prescription Drug Rider*:

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). 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.

The List of Zero Cost Share Medications includes certain Prescription Drug Products under these drug classes or categories:

- Insulins.
- Epinephrine.
- Glucagon.
- Naloxone.
- Albuterol inhalers and nebulized solutions.



Junior Harewood
President

Federal Notices



Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or 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. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

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をご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ **ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយគេគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yániit'igo, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohji' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ:·Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας· Παρακαλείστε να καλέσετε 1-866-633-2446.

ध्यान·आपो:·જો તમે **ગુજરાતી (Gujarati)** બોલતા છો તો આપને ભાષાકીય મદદરૂપ·સેવા· વિના મૂલ્યે પ્રાપ્ય છે·

કૃપા·કરી·1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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 60 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 1-866-633-2446 or 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. ET

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

¹For purposes of the Language Assistance Services and 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 you 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 NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2023:

We² are required by law to protect the privacy of your health information. We are also required to send 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.

The terms "information" or "health information" in this notice include any 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, such as www.myuhc.com. 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 make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may collect, use, and disclose health information needed 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. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **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 Sponsors.** 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. In addition, we 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.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or 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.** We may communicate, electronically or via telephone, these 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:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps 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 interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. 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.
- **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.** We may disclose your health information 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.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information 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 and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 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 Health

11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated 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 promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the 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. To find out where to mail your written authorization and how to revoke an 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** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures 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. **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 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 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 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 will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. 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 or have your information sent to a third party. 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. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive 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; and (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, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. 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 exercising 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.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
 PO Box 740815
 Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint 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.

²This Medical Information 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; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; 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.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; 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, 2023

We³ 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.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices 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 ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, 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, 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*.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- o **Online:** UHC_Civil_Rights@uhc.com
- o **Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- o **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- o **Phone:** Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
- o **Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue. SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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をご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្វែងរកជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłt'igo, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i. T'áá shqódí ninaaltsoos nít'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodílnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.