

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan BCYC (Mod3)

of

Housing Benefits Plan

Group Number: 915422

Effective Date: January 1, 2019

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call UnitedHealthcare Insurance Company's toll-free telephone number for information or to make a complaint at:

Austin **1-800-424-6480**

Dallas **1-800-458-5653**

Houston **1-800-548-1078**

San Antonio **1-800-842-0174**

You may also write to UnitedHealthcare Insurance Company at:

185 Asylum Street

Hartford Connecticut 06013-3408

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may also write the Texas Department of Insurance:

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov.

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de UnitedHealthcare Insurance Company's para obtener informacion o para presentar una queja al:

Austin **1-800-424-6480**

Dallas **1-800-458-5653**

Houston **1-800-548-1078**

San Antonio **1-800-842-0174**

Usted tambien puede escribir a UnitedHealthcare Insurance Company:

185 Asylum Street

Hartford Connecticut 06013-3408

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informacion sobre companias, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 490-1007

Sitio web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov.

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse con la Compania primero. Si la disputa no es resuelta, usted puede comunicarse con el

Departamento de Seguros de Texas.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

ADJUNTE ESTE AVISO A SU POLIZA:

Este aviso es solamente para propositos informativos y no se convierte en parte o en condicion del documento adjunto.

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Questions, Complaints and Appeals Amendment

Outpatient Prescription Drug Rider

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Disclosure of Provider Status

Texas Department of Insurance Exclusive Provider Benefit Plan

Notice

Texas Department of Insurance Preferred Provider Benefit Plan Notice

TEXAS NOTICE OF CERTAIN MANDATORY BENEFITS

Language Assistance Services

Notice of Non-Discrimination

**Important Notices under the Patient Protection and Affordable Care
Act (PPACA)
Statement of Employee Retirement Income Security Act of 1974
(ERISA) Rights
ERISA Statement**

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

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

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

Emergency Health Care Services and Emergency ambulance transportation 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 that are provided at a Network facility by an out-of-Network facility based 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*.

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.

If an amount you owe to an out-of-Network hospital-based Physician for services received by a facility-based provider or an emergency care provider is over \$500, the claim is eligible for mediation of any unpaid amount (not including any applicable Co-payment, deductible and Co-insurance) under Texas Insurance Code Chapter 1467 and Chapter 21. Please note that we will not require that you participate in a mediation and we will not penalize you if do not request mediation. After we request that you initiate mediation we are not responsible for any balance bill that you may receive from a provider, until you request mediation. The hospital-based Physician cannot continue to bill you for any amounts other than, Co-payments, deductibles and Co-insurance until the mediation is completed or withdrawn. If the amount of a claim is changed as a result of mediation, we will adjust the amount of payment based on the results of the mediation.

Please refer to www.tdi.texas.gov/consumer/cpmmediation.html for instructions on how to request mediation.

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

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

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

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. 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.

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

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

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

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

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>Network</p> <p>\$450 per Covered Person, not to exceed \$1,350 for all Covered Persons in a family.</p> <p>Out-of-Network</p> <p>\$450 per Covered Person, not to exceed \$1,350 for all Covered Persons in a family.</p>
Out-of-Pocket Limit	
<p>The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Care Services provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i></p>	<p>Network</p> <p>\$1,000 per Covered Person, not to exceed \$3,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p> <p>Out-of-Network</p> <p>\$1,000 per Covered Person, not to</p>

Payment Term And Description	Amounts
<p>table.</p> <p>The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Care Services. The amount you are required to pay if you do not obtain prior authorization as required. Charges that exceed Allowed Amounts. Co-payments or Co-insurance for any Covered Health Care Service shown in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Limit. 	<p>exceed \$3,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p>
Co-payment	
<p>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.</p> <p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> The applicable Co-payment. The Allowed Amount. <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Co-insurance	
<p>Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
1. Ambulance Services	<p align="center">Prior Authorization Requirement</p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.</p>		
Emergency Ambulance Allowed Amounts for Emergency 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> .	Network <i>Ground Ambulance</i> 20% <i>Air Ambulance</i> 20% Out-of-Network Same as Network	Yes Yes Same as Network	Yes Yes Same as Network
Non-Emergency Ambulance Ground or air ambulance, as appropriate.	Network <i>Ground Ambulance</i> 20% <i>Air Ambulance</i> 20% Out-of-Network <i>Ground Ambulance</i>	Yes Yes 	Yes Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes
2. Clinical Trials			
Prior Authorization Requirement			
You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
3. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement			
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the	Network 20%	Yes	Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .	Out-of-Network 20%	Yes	Yes
4. Dental Services - Accident Only			
<p align="center">Prior Authorization Requirement</p> <p>For Network and Out-of-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.</p>			
	Network 20% Out-of-Network Same as Network	Yes Same as Network	Yes Same as Network
5. Diabetes Services			
<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.</p>			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot	Network Depending upon where the Covered Health Care Service is		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Care <			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years.</p> <p>To receive Network Benefits, you must purchase, rent, or obtain the DME or orthotic from the vendor we identify or purchase it directly from the prescribing Network Physician.</p>	<p>Out-of-Network</p> <p>20%</p>	<p>Yes</p>	<p>Yes</p>
<p>7. Emergency Health Care Services - Outpatient</p>			
<p>Note: 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 or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service.</p> <p>Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be</p>	<p>Network</p> <p>20% after you pay \$150 per visit. If you are admitted as an inpatient to a Hospital directly from the Emergency room you will not have to pay this Co-payment. The Benefits for an Inpatient Stay in a Hospital will apply instead.</p>	<p>Yes</p>	<p>No</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .			
	<i>Out-of-Network</i> Same as Network	Same as Network	Same as Network

8. Gender Dysphoria

Prior Authorization Requirement for Surgical Treatment

You must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.

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

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*.

	<p><i>Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Rider</i>.</p> <p><i>Out-of-Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Rider</i>.</p>
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9. Habilitative Services

Prior Authorization Requirement

For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>(including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.</p> <p>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).</p>			
<p>Inpatient services limited per year as follows:</p> <p>Limit will be the same as, and combined with, those stated under <i>Skilled Nursing Facility/Inpatient Rehabilitation Services</i>.</p> <p>Outpatient therapies:</p> <ul style="list-style-type: none"> Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. <p>For the above outpatient therapies:</p> <p>Limits will be the same as, and combined with, those stated under <i>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</i>.</p>	<p>Network</p> <p><i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p><i>Outpatient</i></p> <p>20%</p>	Yes	Yes
	<p>Out-of-Network</p> <p><i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule</i></p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	of Benefits.		
	Outpatient 20%	Yes	Yes
10. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	Network 20%	Yes	Yes
	Out-of-Network 20%	Yes	Yes
11. Home Health Care			
Prior Authorization Requirement			
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 increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	Network 20%	Yes	Yes
	Out-of-Network		

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	20%	Yes	Yes
12. Hospice Care	<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.</p> <p>In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p>		
	<p>Network</p> <p>20%</p> <p>Out-of-Network</p> <p>20%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
13. Hospital - Inpatient Stay	<p align="center">Prior Authorization Requirement</p> <p>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 (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.</p> <p>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).</p>		
	<p>Network</p> <p>20%</p>	<p>Yes</p>	<p>Yes</p>

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<i>Out-of-Network</i> 20%	Yes	Yes

14. Lab, X-Ray and Diagnostic - Outpatient

Prior Authorization Requirement

For Out-of-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.

Lab Testing - Outpatient	<i>Network</i>		
	None	Yes	No
	<i>Out-of-Network</i>		
	None	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient	<i>Network</i>		
	None	Yes	No
	<i>Out-of-Network</i>		
	None	Yes	No

15. Major Diagnostic and Imaging - Outpatient

Prior Authorization Requirement

For Out-of-Network Benefits for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
	Network 20% Out-of-Network 20%	Yes Yes	Yes Yes
16. Mental Health Care, Serious Mental Health Care, Substance-Related and Addictive Disorders and Chemical Dependency Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care, Serious Mental Health Care, Substance-Related and Addictive Disorders and Chemical Dependency 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 (including Emergency admissions). In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
	Network Inpatient 20%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<i>Outpatient</i> 20% 20% for Partial Hospitalization/Intensive Outpatient Treatment <i>Out-of-Network</i> <i>Inpatient</i> 20% <i>Outpatient</i> 20% 20% for Partial Hospitalization/Intensive Outpatient Treatment	Yes Yes Yes Yes	Yes Yes Yes Yes
17. Ostomy Supplies			
	<i>Network</i> 20% <i>Out-of-Network</i> 20%	Yes Yes	Yes Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
18. Pharmaceutical Products - Outpatient			
	Network 20%	Yes	Yes
	Out-of-Network 20%	Yes	Yes
19. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Allowed Amounts will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	Network 20%	Yes	Yes
	Out-of-Network 20%	Yes	Yes
20. Physician's Office Services - Sickness and Injury			
Prior Authorization Requirement			
For Out-of-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing is performed. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p>Network</p> <p>For Covered Persons under the age of 19:</p> <p>None for a Primary Care Physician office visit; 20% for a Specialist office visit</p> <p>For Covered Persons age 19 and older:</p> <p>20%</p> <p>Out-of-Network</p> <p>20%</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes for a Specialist office visit</p> <p>No for a Primary Care Physician office visit</p> <p>Yes</p> <p>Yes</p>

21. Pregnancy - Maternity Services

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

	Network
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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Out-of-Network Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
22. Preventive Care Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
Physician office services	Network None Out-of-Network 20%	No Yes	No Yes
Lab, X-ray or other preventive tests	Network None Out-of-Network 20%	No Yes	No Yes
Breast pumps	Network None Out-of-Network	No	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	20%	Yes	Yes

23. Prosthetic Devices

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.

<p>Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</p> <p>Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998</i>.</p>	<p>Network</p> <p>20%</p>	<p>Yes</p>	<p>Yes</p>
	<p>Out-of-Network</p> <p>20%</p>	<p>Yes</p>	<p>Yes</p>

24. Reconstructive Procedures

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.

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 (including Emergency admissions).

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p><i>Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Out-of-Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
25. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows:	<i>Network</i>		
<ul style="list-style-type: none"> • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. 	20%	Yes	Yes
	<i>Out-of-Network</i>		
	20%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
26. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 20%	Yes	Yes
	Out-of-Network 20%	Yes	Yes
27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.</p> <p>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).</p>			
Limited to 60 days per year.	Network 20%	Yes	Yes
	Out-of-Network 20%	Yes	Yes
28. Surgery - Outpatient			
<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter</p>			

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
	Network 20% Out-of-Network 20%	Yes Yes	Yes Yes
29. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
30. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement			
For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
	Network 20%	Yes	Yes
	Out-of-Network 20%	Yes	Yes
31. Transplantation Services			
Prior Authorization Requirement			
For 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). If you don't obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid. Out-of-Network Benefits will apply.			
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). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
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).			
For Network Benefits, transplantation services must be received from a Designated Provider.	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under		

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>We will refer you to the Designated Provider most suitable, in our opinion, to treat your condition. In the event that the selected Designated Provider is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Provider within the state of Texas.</p> <p>We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.</p>	<p>each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
32. Urgent Care Center Services			
<p>In addition to the Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none">• Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostic - Outpatient</i>.• Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>.• Outpatient Pharmaceutical Products described under	<p>Network</p> <p>\$50 per visit</p>	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<i>Pharmaceutical Products - Outpatient.</i> <ul style="list-style-type: none">Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>	Out-of-Network 20%	Yes	Yes
33. Virtual Visits			
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.	Network None Out-of-Network 20%	Yes Yes	No Yes
Additional Benefits Required By Texas Law			
34. Acquired Brain Injury			
Prior Authorization Requirement			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .			
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services	Network 20%	Yes	Yes
	Out-of-Network 20%	Yes	Yes
35. Amino Acid-Based Elemental Formulas			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before amino acid-based formulas are received or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed \$500.			
Benefits under this category will be provided for any Medically Necessary services that are provided in connection with the administration of the formula.	Network 20%	Yes	Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Benefits for the amino acid-based elemental formulas will be provided as described under the <i>Outpatient Prescription Drug Rider</i> .	Out-of-Network 20%	Yes	Yes
36. Developmental Delay Services			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any applicable pre-authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
37. Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings			
	Network None Out-of-Network 20%	Yes Yes	No Yes

<i>When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.</i>			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
38. Osteoporosis Detection and Prevention			
	<p><i>Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Out-of-Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
39. Phenylketonuria and Other Heritable Diseases			
	<p><i>Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Out-of-Network</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Covered Health Care Services provided by an out-of-Network provider (other than services otherwise arranged by us), you will be responsible to the out-of-Network provider for any amount billed that is greater than the amount we determine to be an Allowed Amount as described below. For Out-of-Network

Benefits, 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. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

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

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, 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.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are determined, based on:
 - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
 - If rates have not been negotiated, then one of the following amounts:
 - ♦ Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - 50% of *CMS* for the same or similar laboratory service.
 - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
 - ♦ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.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.

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

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

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

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

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

For Emergency Health Care Services and Emergency ambulance transportation provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or determined based upon the higher of:

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

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

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

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here; however, you should contact us if you receive such a bill and we will work with the provider so that you are only responsible for your Co-payment, Co-insurance or deductible.

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

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.

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

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

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

Designated Providers

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

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

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

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

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

When Covered Health Care Services are rendered to a Covered Person by an out-of-Network provider because there was not a Network provider reasonably available, we will:

- Pay the claim, at a minimum, at the usual, reasonable or customary charges for the Covered Health Care Service, less any applicable Co-insurance, Co-payment or Annual Deductible amount;
- Pay the claim at the Network Benefit Co-insurance level; and
- In addition to any amount that would have been credited had the provider been a Network provider, credit any out-of-pocket amounts you paid to the out-of-Network provider for charges for Covered Health Care Services that were above and beyond the Allowable Amount toward the Annual Deductible and Out-of-Pocket Limit applicable to Network services.

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.

Continuity of Care

If you are undergoing a course of treatment from a Network Physician or provider at the time that Network Physician or provider's contract terminates with us, you may be entitled to continue that care at the Network benefit level. Continuity of care is available in special circumstances in which the treating Physician or health care provider reasonably believes discontinuing care by the treating Physician could cause harm to the Covered Person. Special circumstances include Covered Persons with a disability, acute condition, life-threatening illness, or past the 24th week of Pregnancy.

The continuity of care request must be submitted by the treating Physician or provider. If continuity of care is approved, it may not be continued beyond 90 days after the Physician or provider's contract is terminated, or nine months after the Physician or provider's contract is terminated, if the Covered Person has been diagnosed as having a terminal illness at the time of termination. If the Covered Person is past the 24th week of Pregnancy at the time of termination, coverage at the Network level will continue.

through the delivery of the child, immediate postpartum care and the follow-up checkup within the six week period after delivery.

If you have questions regarding this continuity of care policy or would like help determining whether you are eligible for continuity of care Benefits, please contact us at www.myuhc.com or the telephone number on your ID card.

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

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

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

Can This Certificate Change?

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

Other Information You Should Have

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

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

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

We are delivering the Policy in Texas. The Policy is governed by ERISA unless the Group is not an employee health and welfare plan as defined by ERISA. To the extent that state law applies, Texas law governs the Policy.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

Your Responsibilities

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. In general, 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 and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount for out-of-Network expenses.

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We 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:

- 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.

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

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount 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. Ambulance Services

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

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

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

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

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

2. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition:

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.

- Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services that clearly do 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.
- Any item or service that is not a Covered Health Care Service, regardless of whether the item or service is required in connection with the participation in a clinical trial.
- Any item or service that is specifically excluded from coverage under this Policy.

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

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

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

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

3. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

4. Dental Services - Accident Only

Dental services when all of the following are true:

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

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

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

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

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

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

5. Diabetes Services

Diabetes equipment, diabetes supplies and diabetes self-management training programs when provided by or under the direction of a Doctor of Medicine, Doctor of Osteopathy or a Certified Educator. Benefits also include new treatment modalities upon the approval of the *FDA*, supplies, including medications and equipment for the control of diabetes shall be dispensed as written, including brand-name products, unless substitution is approved by the Physician or practitioner who issues the written order.

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits are also available for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime and periodic continuing education training as warranted by the development of new techniques and treatment of diabetes.

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

Diabetic Self-Management Items

Diabetes equipment is limited to:

- Blood glucose monitors (including noninvasive monitors and monitors designed to be used by blind individuals).
- Insulin pumps, both external and implantable, and associated appurtenances which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin and other required disposable supplies. Benefits are included for repairs and necessary maintenance of insulin pumps that are not otherwise provided for under warranty or purchase agreement. Benefits are also included for rental fees for pumps during the repair and necessary maintenance of insulin pumps (neither of which shall exceed the purchase price of a similar replacement pump).
- Podiatric appliances including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

Diabetes supplies are limited to:

- Test strips for blood glucose monitors.

- Lancet and lancet devices.
- Visual reading and urine testing strips and tablets that test for glucose, ketones and protein.
- Insulin and insulin analog preparations.
- Injection aids, including devices used to assist with insulin injection and needleless systems.
- Insulin syringes.
- Biohazard disposal containers.
- Glucagon emergency kits.
- Prescription and non-prescription oral agents for controlling blood sugar levels.

Note: If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the diabetes supplies above will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this Benefit category.

6. 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, including external speech processor and controller with necessary components replacement every three years. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*. Benefits for cochlear implants are limited to one in each ear with internal replacement as medically or audilogically necessary.

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

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment 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.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered exoskeleton devices.

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

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

7. 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 or Freestanding Emergency Medical Care Facility or comparable emergency facility.

If a Covered Person cannot reasonably reach a Network provider, we shall provide reimbursement for the following Emergency Health Care Services at the Network provider level of Benefits until the Covered Person can reasonably be expected to transfer to a Network provider:

- A medical screening exam or other evaluation required by state or federal law to be provided in the emergency facility or a Hospital that is necessary to determine whether a medical emergency condition exists;
- Necessary Emergency Health Care Services, including the treatment and stabilization of an emergency medical condition; and
- Services originating in a Hospital emergency facility or Freestanding Emergency Medical Care Facility following treatment and stabilization of an emergency medical condition.

When Emergency Health Care Services are received in a Physician's office, the Benefits will be paid as described in *Physician's Office Services - Sickness and Injury* below.

When Emergency Health Care Services are received on an inpatient basis, Benefits will be paid as described in *Hospital - Inpatient Stay* below.

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).

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

8. 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*.

9. 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.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.

- Educational services otherwise paid under state or federal law.

We may require the following be provided:

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

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

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

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

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

10. 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 due to a written recommendation by a Physician. Benefits are provided for the hearing aid, associated fitting charges and testing, dispensing services and the provision of ear molds as necessary to maintain optimal fit of the hearing aid.

Benefits for habilitation and rehabilitation services as necessary for educational gain related to hearing aids and cochlear implants are a Covered Health Care Service for which Benefits are available under *Habilitative Services* and *Rehabilitative Services-Outpatient Therapy and Manipulative Treatment*.

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*. Benefits are limited to one bone anchored hearing aid per Covered Person during the entire period of time the Covered Person is enrolled under the Policy. Benefits do not include repairs and/or replacements for bone anchored hearing aids, other than for malfunctions.

11. 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 a licensed vocational nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Physical, occupational, speech or respiratory therapy.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Medical equipment and supplies other than drugs or medicines.

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

12. 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.

13. 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).
- Inpatient care for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer. The Covered Person and the treating Physician may determine that a shorter period of inpatient care is appropriate.
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

14. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography, including annual breast cancer screenings by all forms of Low-dose Mammography in females 35 years of age and older for the presence of occult breast cancer, including 3-D imaging.
- Noninvasive screening tests for atherosclerosis and abnormal artery structure such as ultrasonography measuring carotid intima-media thickening and plaque.

- Prostate-specific antigen test for the detection of prostate cancer.

Benefits include:

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

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

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*.

15. 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.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Computed tomography (CT) scan measuring coronary artery calcification.

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

16. Mental Health Care, Serious Mental Health Care, Substance-Related and Addictive Disorders and Chemical Dependency Services

Mental Health Care, Serious Mental Health Care, Substance-Related and Addictive Disorders and Chemical Dependency Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- 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.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)*) that are the following:
 - Focused on the treatment of core deficits of Autism Spectrum Disorder.
 - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
 - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder including the screening of a child for 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 are provided for generally recognized services when prescribed by the Enrolled Dependent child's Primary Care Physician in the treatment plan recommended by that Physician. The individual providing generally recognized services must be a health care practitioner who is licensed, certified, or registered by an appropriate agency of the State of Texas; whose professional credentials are recognized and accepted by an appropriate agency of the United States; who is certified as a provider under the TRICARE military health system; or other qualified provider acting under the supervision of a health care practitioner listed above.

- Mental Health Care Services for the following psychiatric illnesses (defined as Serious Mental Illness in *Section 9: Defined Terms*):
 - Bipolar disorders (hypomanic, manic, depressive, and mixed).
 - Depression in childhood and adolescence.
 - Major depressive disorders (single episode or recurrent).
 - Obsessive-compulsive disorders.
 - Paranoid and other psychotic disorders.
 - Schizo-affective disorders (bipolar or depressive).
 - Schizophrenia.

Benefits are provided for alternative Mental Health Care Services for treatment of a Serious Mental Illness in a Residential Treatment Center for Children and Adolescents or from a Crisis Stabilization Unit, as required by State of Texas insurance law.

- Chemical Dependency services, including detoxification from abusive chemicals or substances, limited to physical detoxification when necessary to protect your physical health and well-being. Detoxification is the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

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 referrals to providers and coordination of care.

17. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

18. 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 Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

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

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

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

19. Physician Fees for Surgical and Medical Services

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

Benefits include Telehealth Services or Telemedicine Medical Services. An in-person consultation is not required between the health care provider and the patient for services to be provided. Services provided by telemedicine and telehealth are subject to the same terms and conditions of the Policy as any service provided in-person.

You may find additional information regarding Telehealth Services or Telemedicine Medical Services at www.myuhc.com.

20. 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 injections.

Benefits also include necessary diagnostic follow-up care relating to the screening test for hearing loss for Dependent child.

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

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*.

21. Pregnancy - Maternity Services

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

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 also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.

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

- 48 hours for the mother and newborn child following an uncomplicated normal vaginal delivery.
- 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery.
- 96 hours for the mother and newborn child following a non-elective 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 the discharge occurs earlier or if the delivery does not occur in a Hospital or other facility, Benefits are included for post-delivery care when provided by a Physician, a registered nurse or other appropriately licensed provider, either in the mother's home or at another location determined to be appropriate.

Post-delivery care includes services provided in accordance with accepted maternal and neonatal physical assessment, parent education, breast or bottle feeding, educational/training and performance of necessary and appropriate clinical tests.

22. 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*.

Immunizations for children include, but are not limited to:

- ♦ Diphtheria.
 - ♦ Haemophilus influenza type B.
 - ♦ Hepatitis B.
 - ♦ Measles.
 - ♦ Mumps.
 - ♦ Pertussis.
 - ♦ Polio.
 - ♦ Rubella.
 - ♦ Tetanus.
 - ♦ Varicella.
 - ♦ Any other immunization required for children by law.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
 - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*, including contraceptive services and supplies. Women may access obstetrics and gynecology services directly from an obstetrician or gynecologist. You may receive these services without prior authorization or a referral from your Primary Care Physician.

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

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

- Which pump is the most cost effective.

- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of purchase or rental.

23. 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 other than breast prostheses. 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 most appropriate model of prosthetic device that meets the minimum specifications for your needs, as determined by your treating Physician. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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

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

24. 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.

Benefits are provided for the reconstructive procedures for craniofacial abnormalities to improve the function of, or attempt to create the normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumor, infections, or disease. (Benefits are not available for cranial banding, which is not a Covered Health Care Service.)

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

physical complications, including lymphedemas, at all stages of mastectomy, 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.

25. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

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

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

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

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

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, Autism Spectrum Disorder or determined to be Medically Necessary by your Physician. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Benefits are available only for rehabilitation services that are expected to restore a Covered Person to the previous level of functioning (not to exceed activities of daily living). Benefits for rehabilitation services are not available for services that are expected to provide a higher level of functioning than the Covered Person previously possessed. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

26. 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*.)
- Colorectal cancer screenings for Covered Persons at a normal risk of developing colon cancer including:
 - A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years.
 - A colonoscopy performed every 10 years.

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

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

27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

28. Surgery - Outpatient

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

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

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

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

Benefits include:

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

29. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles; including the jaw and the craniomandibular joint, which are required as a result of an accident, trauma, congenital defect, developmental defect, or pathology.

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

Non-surgical treatment including:

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

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

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

Benefits for surgical services include:

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

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

30. 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 for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

31. Transplantation Services

Organ and tissue transplants including CAR-T cell therapy 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.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small bowel.
- Pancreas.
- Small bowel.
- Cornea.

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

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

32. 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*.

33. Virtual Visits

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through live audio and video technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio and video technology 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.

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

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

Additional Benefits Required By Texas Law

34. Acquired Brain Injury

Benefits are provided for Covered Health Care Services that are determined by a Physician to be Medically Necessary as a result of and related to an acquired brain injury. Acquired brain injury is a neurological insult to the brain which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. Benefits are provided for the Covered Health Care Services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an acquired brain injury and provided by or under the direction of a Physician with the goal of returning the Covered Person to, or maintaining the Covered Person in, the most integrated living environment appropriate to the Covered Person.

- Cognitive communication therapy. Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- Cognitive rehabilitation therapy. Services designed to address therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits.
- Community reintegration services. Services that facilitate the continuum of care as an affected individual transitions into the community.
- Neurobehavioral testing. An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
- Neurobehavioral treatment. Interventions that focus on behavior and the variables that control behavior.
- Neurocognitive rehabilitation. Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

- Neurocognitive therapy. Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- Neurofeedback therapy. Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- Neurophysiological testing. An evaluation of the functions of the nervous system.
- Neurophysiological treatment. Interventions that focus on the functions of the nervous system.
- Neuropsychological testing. The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuropsychological treatment. Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Outpatient day treatment services - Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.
- Post-acute care treatment services - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
- Post-acute care services necessary as a result of and related to an acquired brain injury are limited to the following: post-acute care treatment is limited to reasonable expenses related to periodic reevaluation of care provided to an individual who has incurred an acquired brain injury, has been unresponsive to treatment and becomes responsive to treatment at a later date. Reasonable costs may be determined by cost; the time that has expired since the previous evaluation; any difference in the expertise of the Physician or practitioner performing the evaluation; changes in technology and advances in medicine. For services provided by a licensed Assisted Living Facility through a program that includes an overnight stay, each overnight stay is equal to a visit.
- Post-acute transition services. Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- Psychophysiological testing. An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment. Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Remediation. The process of restoring or improving a specific function.
- Treatment facilities. Treatment for an acquired brain injury may be provided at a facility at which the services listed above may be provided including a Hospital, acute or post-acute rehabilitation hospital and Assisted Living Facility. Although Benefits may be available for services at Assisted Living Facilities, Benefits are not available for Custodial Care, Private Duty Nursing, domiciliary care, and personal care assistants as outlined in *Types of Care in Section 2: Exclusions and Limitations* in this *Certificate of Coverage*, regardless of where the services are provided.

35. Amino Acid-Based Elemental Formulas

Benefits are provided for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
- Severe food protein-induced enterocolitis syndrome.
- Eosinophilic disorders, as evidenced by the results of a biopsy.
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Benefits will also be provided for any Medically Necessary services associated with the administration of the formula.

Benefits for the amino acid-based elemental formulas will be provided under the *Outpatient Prescription Drug Rider*.

For Benefits to be provided, the treating Physician must issue a written order stating that the amino acid-based elemental formula is Medically Necessary for the treatment of a Covered Person who is diagnosed with at least one of the diseases or disorders listed above.

36. Developmental Delay Services

Rehabilitative and habilitative services that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the *Interagency Council on Early Childhood Intervention*.

Covered Health Care Services include:

- Occupational therapy evaluations and services.
- Physical therapy evaluations and services.
- Speech therapy evaluations and services.
- Dietary or nutritional evaluations.

37. Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings

Benefits for human papillomavirus, cervical cancer screenings and ovarian cancer screenings will be provided to each woman 18 years of age and older that is an Eligible Person enrolled under the Policy.

Coverage includes the following:

- An annual medically recognized diagnostic exam for the early detection of cervical cancer;
- A conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the *U.S. Food and Drug Administration (FDA)*, alone or in combination with a test approved by the *FDA* for the detection of the human papillomavirus.
- An annual CA 125 blood test for the early detection of ovarian cancer.
- Screenings provided under this section must be performed in accordance with the guidelines adopted by:
 - *The American College of Obstetricians and Gynecologists*; or
 - Another similar national organization of medical professionals recognized by the commissioner.

Human papillomavirus and cervical cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* or as provided for in

comprehensive guidelines supported by the *Health Resource and Services Administration* are described under *Preventive Care Services*.

38. Osteoporosis Detection and Prevention

Benefits for a medically accepted bone mass measurements for the detection of low bone mass, when provided by or under the direction of a Physician. Benefits are provided only to a Covered Person who meets at least one of the following:

- A postmenopausal woman who is not receiving estrogen replacement therapy.
- An individual with vertebral abnormalities, primary hyperparathyroidism, or history of bone fractures.
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

39. Phenylketonuria and Other Heritable Diseases

Benefits are provided for formulas necessary to treat phenylketonuria or heritable diseases.

Heritable disease means an inherited disease that may result in mental or physical retardation or death.

Phenylketonuria (PKU) means an inherited condition that, if not treated, may cause severe mental retardation.

Benefits for the phenylketonuria or other heritable diseases will be provided under the *Outpatient Prescription Drug Rider*.

Benefits for phenylketonuria and other heritable diseases will be paid the same as other drugs that are available when prescribed by a Physician.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

B. Dental

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

This exclusion does not apply to 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.
- Services required by a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia because of a documented physical, mental or medical reason.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

- Removal, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

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.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to help in communication and speech except for speech aid 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*.
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices 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 prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the prescription and non-prescription oral agents will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under the *Certificate*.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
5. Growth hormone therapy.
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations will occur no more often than annually on the Policy anniversary date.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations will occur no more often than annually on the Policy anniversary date.
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 will occur no more often than annually on the Policy anniversary date.

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 will occur no more often than annually on the Policy anniversary date.

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 the cutting or removal of corns and calluses. This exclusion does not apply to 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. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes. This exclusion does not apply to podiatric appliances or therapeutic footwear as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
7. Shoe orthotics. This exclusion does not apply to orthotics as described under *Diabetes Services* or *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
8. Shoe inserts.
9. Arch supports.

G. Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.

- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

H. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.
- Urinary catheters.

This exclusion does not apply to:

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

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

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

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

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, 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.

J. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical 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 including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk. This exclusion does not apply to amino-acid based elemental formulas as described under *Amino Acid-Based Elemental Formulas* 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. This exclusion does not apply to:
 - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Care Services*, which meet the definition of a Covered Health Care Service.
 - Amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Care Services*.
 - Formulas for phenylketonuria (PKU) or other heritable diseases as described under *Phenylketonuria and Other Heritable Diseases* in *Section 1: Covered Health Care Services*.

K. Personal Care, Comfort or Convenience

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

- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke.
8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury.
10. 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.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. 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.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
15. *Helicobacter pylori* (*H. pylori*) serologic testing.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an

employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

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

This exclusion does not apply to mammography.

O. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
6. Fetal reduction surgery.
7. In vitro fertilization regardless of the reason for treatment.

P. 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.

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

Q. Transplants

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

R. Travel

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

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. 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. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

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.
 - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
 7. Charges in excess of the Allowed Amount or in excess of any specified limitation.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Autopsy.
 10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
 11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

What If You Are Eligible for Medicare?

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

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

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.
- Legal guardianship.
- Court or administrative order, including a *Qualified Medical Child Support Order* for a Dependent Child.

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

Coverage for a new Dependent child by birth or adoption begins on the date of the event and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, the Subscriber must notify us of

the event and pay any required Premium within 31 days of the event. Benefits for Covered Health Care Services for congenital defects and birth abnormalities (including Congenital Anomalies) are available at the same level as those for any other Sickness or Injury.

Coverage for a Dependent child when required by a medical support order begins on the date of receipt of either the medical support order, or the notice of the medical support order, and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, we must receive a completed enrollment form and payment of any required Premium within 31 days of receipt of the medical support order. The Subscriber, the custodial parent, a child support agency, or the Dependent child (if over age 18) may complete and sign the enrollment form on behalf of the Dependent child. If the Eligible Person is not already enrolled, he or she is also eligible to enroll if required by a medical support order to provide health care coverage to his or her Dependent child. The Eligible Person must provide proof, satisfactory to us, of the requirement to provide health care coverage.

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.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.
- Court or administrative order.

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 as well as a child of a covered employee who has lost coverage under *Chapter 62 Health and Safety Code*, *Child Health Plan for Certain Low-Income Children* or *Title XIX of the Social Security Act* (42 U.S.C. §§1396, et seq., *Grants to States for Medical Assistance Programs*) other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. §1396, *Program for Distribution of Pediatric Vaccines*)).

- 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 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.

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**

For Texas residents, 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 and we receive written notice from the Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage ends on the last day of the calendar month in which we receive written notice from the Group instructing us to end your coverage, or the date requested in the notice, if later. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

For Texas residents, 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 and we receive written notice from the Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage ends on the last day of the calendar month in which we receive written notice from the Group instructing us to end your coverage, or the date requested in the notice, if later. The Group is responsible for providing the required notice to us to end your coverage.

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

Fraud or Intentional Misrepresentation of a Material Fact

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

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

Coverage for a Disabled Dependent Child

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

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or 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.
- 90 days from the date coverage would have ended when the entire Policy ends.

Continuation of Coverage

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

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator 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 of Coverage under State Law

You may elect state continuation as described under the State Continuation Coverage provisions below.

Qualifying Events for State Continuation Coverage Due to Reasons other than Severance of the Family Relationship

A Covered Person whose coverage terminates due to any reason except involuntary termination for cause, and who has been continuously covered under the Policy (and under any group contract providing similar services and benefits that it replaced) for at least three consecutive months immediately prior to termination, is entitled to continue coverage under state law. A person whose coverage terminates due to severance of the family relationship may either continue coverage as described immediately below, or if he or she meets the requirements described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*, may continue coverage as described in that provision.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

The Covered Person must provide a written request for continuation coverage to the Group's designated Plan Administrator within 60 days after the later of these dates:

- The date group coverage would otherwise terminate.
- The date the Covered Person is given notice of the right to elect continuation.

The Covered Person must pay the initial Premium for the continuation coverage to the Group's designated Plan Administrator within 45 days after the date of the initial election of coverage continuation. Following the payment of the initial Premium, the Covered Person must pay the monthly Premium for the coverage continuation to the designated Plan Administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Terminating Events for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

State Continuation coverage due to reasons other than severance of the family relationship will end on the earliest of the following dates:

- Nine months from the date state continuation coverage was elected, if the Covered Person is not eligible for continuation of coverage under Federal law (COBRA).
- Six months from the date state continuation coverage was elected, if the state continuation coverage followed continuation coverage under Federal law (COBRA).
- The date coverage ends for failure to make timely payment of the Premium.

Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship

If both of the following are true, a Covered Person whose coverage terminates may elect state continuation coverage under the Policy:

- The Covered Person has been covered under the Policy for at least one year, or is an infant under one year of age.
- The Covered Person's coverage under the Policy was terminated for one of the reasons set forth below:
 - Termination of the Subscriber from employment with the Group.
 - Death of the Subscriber.
 - Divorce of the Subscriber.
 - Retirement of the Subscriber.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Severance of the Family Relationship

A Covered Person must provide written notice to the Group within 15 days of any severance of the family relationship that might qualify for the continuation as described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*. Upon receipt of such notice, or upon receipt of notice of the Subscriber's death or retirement, the Group shall immediately give written notice of the right to state continuation to each affected Enrolled Dependent. Within 60 days of severance of the family relationship or the Subscriber's death or retirement, the Enrolled Dependent must give written notice to the Group of his or her intent to elect state continuation. Coverage under the Policy remains in effect during the 60-day election period provided the required Premium is paid. The Covered Person must pay the monthly Premium for the coverage continuation to the designated Plan Administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Termination Events for State Continuation Coverage Due to Severance of the Family Relationship

State continuation coverage due to severance of the family relationship will end on the earliest of the following dates:

- Three years from the date that the family relationship was severed or the date of the Subscriber's death or retirement.
- The date the Covered Person fails to make timely payment of the Premium.

The date the Covered Person becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program.

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 15 months of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

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

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

Payment of Benefits

If you provide written authorization to pay Benefits to the Physician or other health care provider and provides it to us with a claim for benefits, all or a portion of any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you, your designated beneficiary, your estate, or if you are a minor or otherwise not competent to give a valid release, your parent, guardian, or other person actually supporting you, unless either of the following is true:

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

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.

Payment/Reimbursement for Certain Publicly Provided Services

As required by Texas law, we will pay Benefits on behalf of a child to the *Texas Department of Human Services*, if;

- The parent who purchased the Policy or who is required to pay child support by a court order or court-approved agreement is;
 - a possessory conservator of the child under a court order issued in this state; or
 - not entitled to possession or access to the child.
- The *Texas Department of Human Services* is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and
- We are notified, through an attachment to the claim for Benefits at the time the claim is first submitted, that the Benefits must be paid directly to the *Texas Department of Human Services*.

Payment/Reimbursement of Benefits to Conservator of Minor

As required by Texas law, we will pay Benefits to a court appointed possessory or managing conservator of a child if the court appointed person includes the following information when submitting a claim to us;

- Written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and
- A certified copy of a court order designating the person as a possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides.

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.

We shall promptly investigate each complaint. The total time for acknowledgement, investigation and resolution of the complaint shall not exceed 30 calendar days after we receive the written complaint or the one-page complaint form.

Complaints concerning presently occurring Emergencies or denials of continued stays for hospitalization shall be investigated and resolved in accordance with the medical immediacy, and shall not exceed one business day from receipt of the complaint.

We shall not engage in any retaliatory action against any Covered Person. We shall not retaliate for any reason including, for example, cancellation of coverage or refusal to renew coverage because the Covered Person or person acting on behalf of the Covered Person has filed a complaint against the Policy or has appealed a decision.

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. If your appeal relates to a non-clinical denial, refer to *How to Appeal a Non-Clinical Benefit Determination* below.

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.

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 for you to receive services is between you and your Physician.

Prior Authorization of Services

A request for prior authorization of services is a notification to us of proposed services that will result in one of the following:

- A Pre-authorization;
- An Adverse Determination; or
- When there are no clinical issues for us to determine, a confirmation of receipt of your request.

If you receive an Adverse Determination in response to your request for prior authorization of services, you may appeal the decision. Please refer to *Procedures for Appealing an Adverse Determination* below. If you receive a pre-service Non-clinical Benefit Determination from us in response to your request for prior authorization of services, you may appeal our decision. Please refer to *How to Appeal a Non-Clinical Benefit Determination* below.

For procedures associated with urgent requests for prior authorization of services, see *Urgent Appeals that Require Immediate Action* below.

Procedures for Appealing an Adverse Determination

An Adverse Determination is a decision that is made by us or our agent that the health care services furnished or proposed to be furnished to a Covered Person are:

- Not Medically Necessary or appropriate.
- Experimental or Investigational Services.

An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is Medically Necessary. A complete definition of Adverse Determination is contained in *Section 9: Defined Terms*.

If you receive an Adverse Determination in response to a claim or a request for prior authorization of services, you, your designated representative or your provider of record may contact us orally or in writing to formally request an appeal.

If you, your designated representative or your provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your provider of record a one-page appeal form.

If you, your designated representative or your provider of record chose to appeal in writing, your request for an Adverse Determination 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.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Within two working days after the utilization review agent receives a request for a utilization review and all the information necessary to complete the review, an Adverse Determination Notice will be provided to you, your designated representative or your provider of record.

Time for Notice of Adverse Determination

A utilization review agent shall provide notice of an Adverse Determination as follows:

- With respect to a patient who is hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the Adverse Determination;
- With respect to a patient who is not hospitalized at the time of the Adverse Determination, within three working days in writing to the provider of record and the patient; or
- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating Physician or other health care provider, notice will be provided to the treating Physician or other health care provider no later than one hour after the time of the request.
- A utilization review agent shall provide notice of an Adverse Determination for a concurrent review of the provision of the prescription drug or intravenous infusions for which the patient is receiving health benefits under this Policy no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued.

Denied Appeals Specialty Provider Review

If we uphold the clinical appeal, your provider may, within 10 working days of the appeal denial, request a review by a specialty provider by submitting a written request showing good cause for the additional review.

Independent Review Organization

If the appeal of an Adverse Determination is denied by us or our utilization review agent, you, your designated representative or your provider of record have the right to request a review of that decision by an Independent Review Organization (IRO).

If all of the following apply, you may request a review of a clinical benefit determination or an Adverse Determination by an IRO:

- Your complaint relates to a clinical benefit determination or an Adverse Determination.
- The clinical benefit determination or Adverse Determination is upheld.
- You have exhausted the clinical appeal procedure as described above.

When we or our utilization review agent notifies you, your designated representative or your provider of record that the appeal of the Adverse Determination has been denied:

- We or our utilization review agent will provide to you, your designated representative or your provider of record information on how to appeal the denial of an Adverse Determination to an IRO.
- We or our utilization review agent will send you, your designated representative or your provider of record the form or forms that must be completed and returned to us or our utilization review agent to begin the independent review process.
- After we receive a request for a review by an IRO, we will notify the *Texas Department of Insurance* (TDI) within one working day from the date the request for an independent review is received.
- We or our utilization review agent will provide a copy of any medical records relevant to the review, any documents used to make the determination, written notification, and any other documents submitted in support of the appeal to the IRO no later than the third business day after the request for review is received.
- TDI will, within one working day of receipt of a complete request for an independent review, randomly assign an IRO to conduct an independent review.
- In circumstances involving a life-threatening condition or an urgent care situation, if we have failed to meet the internal appeal process timeframes stated above, or if you are denied prescription drugs or intravenous infusion for which you are receiving benefits you are entitled to an immediate review by an IRO. In life-threatening or urgent care situations, you, your designated representative or your provider of record may contact us or our utilization review agent by telephone to request the review by the IRO and we or our utilization review agent will provide the required information. A determination will be made no later than the earlier of the following:
 - The third day after the date that the IRO receives the necessary information to make the determination; or
 - The third day after the date the IRO receives the request for the determination be made (or by the eighth day after the IRO receives the request if the review involves a health care service provided by a person eligible for workers' compensation medical benefits).
- For non-life threatening conditions the determination will be made on the 15th day after the date the IRO receives the information necessary to make the determination; or on the 20th day after the date the IRO receives the request that the determination be made.

We will pay for the costs relating to this review and will comply with the decision. You may request a review by an IRO without exhausting the appeal procedure if the Adverse Determination relates to a life-threatening condition or an urgent care situation.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Expedited Appeal for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, Prescription Drugs or intravenous infusions will include a review by a health care provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you of the decision by the end of the next business day following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.
- The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.
- If you are not satisfied with our decision, you have a right take your complaint to the *Texas Department of Insurance*.

How to Appeal a Non-Clinical Benefit Determination

If you receive a benefit denial in response to a request for prior authorization of services or as a result of a post service claim determination, you, your designated representative or your provider of record can contact us orally or in writing to formally request an appeal.

Your request 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.
- Non-clinical Benefit Determination is a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance policy without reference to the medical necessity or appropriateness of the services. A Non-clinical Benefit Determination that services are not covered is not an Adverse Determination.

For appeals of Non-clinical Benefit Determinations and post service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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 specific to Texas law regarding coordination of 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, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage

under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense. A Policy may not reduce benefits on the basis that: another Plan exists and the Covered Person did not enroll in that Plan; a person is or could have been covered under another Plan, except with respect to Part B of Medicare; or a person has elected an option under another Plan providing a lower level of benefits than another option that could have been elected.

- 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. If the Primary Plan is a Closed Panel plan and the Secondary Plan is not, the Secondary Plan must pay or provide benefits as if it were the Primary Plan when a Covered Person uses an out-of-Network Physician, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.
- E. When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.
- F. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this subchapter decide the order in which Secondary Plans' benefits are determined in relation to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or plans and the benefits of any other Plan that, under the rules of this subchapter, has its benefits determined before those of that Secondary Plan.
- G. 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, should the plan wish to coordinate benefits, the Secondary Plan must 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 results in the total benefits paid or provided by all Plans for the claim equaling 100 percent of the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

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

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare,

we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

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

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

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not 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:

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

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; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

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 do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Co-payments or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

In accordance with state and federal law, we will do all of the following:

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

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

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

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

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

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date after a 60-day written notice has been sent to the Group and to the Commissioner, 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.

How Are Benefits Paid When You Are Medicare Eligible?

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

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

Subrogation and Reimbursement

We have the right to subrogation and reimbursement. 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

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.

Reimbursement

Reimbursement is the payment by you out of the recovery received from any third party to us to be limited to the amount of medical Benefits paid by us. We may request and receive reimbursement of any type of recovery for the reasonable value of any services and Benefits we provided to you subject to Section 140.005 of the Civil Practice and Remedies Code. We may receive reimbursement for the total amount of past Benefits paid, not to exceed the amount you receive from any third party.

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. We may pursue recovery against an underinsured or uninsured motorist for medical payments coverage if the Covered Person or their immediate family did not pay the premiums for the coverage.
- 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.
 - Contacting us to obtain 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.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party.
- 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.
- 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.
- 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.
- We may 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. We may also file a lawsuit to enforce the plans right of subrogation or reimbursement.
- 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 provides 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 the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

Is There a Limitation of Action?

Prior to bringing any legal action against us to recover reimbursement we recommend that you complete all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. If you want to bring a legal action against us you must do so after the 61st day written proof of loss is filed or 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

Adverse Determination - a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not Medically Necessary or appropriate, or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

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

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. 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, and includes a Crisis Stabilization Unit, a Psychiatric Day Treatment Facility, a Mental Health Center, and a Residential Treatment Center for Children and Adolescents.

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.

Annual Deductible - the total of the Allowed Amount 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. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Living Facility - a facility regulated by Chapter 247 of the Health and Safety Code.

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

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

Breast Tomosynthesis - a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnosis may be determined.

Chemical Dependency - the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance. For the purposes of this definition, "controlled substance" means an

abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code.

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

Complications of Pregnancy - conditions requiring hospital confinement (when Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy or are caused by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct Complication of Pregnancy; and non-elective cesarean section, termination of ectopic Pregnancy and spontaneous termination of Pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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

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

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

- The Co-payment.
- The Allowed Amount.

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:

- 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.

Crisis Stabilization Unit - a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structure activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

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.

Dependent - the Subscriber's legal spouse, including common law 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 who the Subscriber is a party in a suit seeking 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 of any age who is or becomes disabled and dependent upon the Subscriber.
- A Dependent includes a grandchild of the Subscriber, who is unmarried, under 26 years of age and is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made.

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

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

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

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers 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 condition; 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 and video technology.

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; or
- Serious disfigurement.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, 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, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
- Services originated in a hospital emergency facility, Freestanding Emergency Medical Care Facility, or comparable emergency facility to evaluate and stabilize an emergency medical condition.

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:

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

Exceptions:

- Drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following:
 - Has been approved by the *FDA* for at least one indication.
 - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
 - ♦ A prescription drug reference compendium approved by the *Commissioner of the Texas Department of Insurance*.
 - ♦ Substantially accepted peer-reviewed medical literature.
- 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 Emergency Medical Care Facility - a facility, structurally separate and distinct from a Hospital that receives an individual and provides Emergency care.

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

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.

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

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

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

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

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

Independent Review Organization (IRO) - an organization certified by the State of Texas to hear appeals of Adverse Determinations.

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

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

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

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

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

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

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

Intermittent Care - skilled nursing care that is provided 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.

Low-dose Mammography - includes:

- The x-ray exam of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast;
- Digital mammography; or
- Breast Tomosynthesis.

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 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, that are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, 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) 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, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UnitedHealthcareOnline.

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

Mental Health Care Services - Covered Health Care Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of

the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health Center - a tax supported institution of the State of Texas, including community centers for mental health and mental retardation services.

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 *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

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

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

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

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

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

Non-Clinical Benefit Determination - a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance Policy without reference to the medical necessity or appropriateness of the services. A Non-clinical Benefit Determination that services are not covered is not an Adverse Determination.

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.

Pharmaceutical Product List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject, from time to time, to our review and change. However, changes will occur no more often than annually on the Contract anniversary date. You may find out which tier a particular Pharmaceutical Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Please Note: Any acupuncturist, advanced practice nurse, audiologist, chemical dependency counselor, dietitian, hearing instrument fitter and dispenser, hospitalist, licensed clinical social worker, licensed professional counselor, marriage and family therapist, occupational therapist, physical therapist, Physician, physician assistant, psychological associate, speech language pathologies, surgical assistant, 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.

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

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, placing Pharmaceutical Products into specific tiers.

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:

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

Psychiatric Day Treatment Facility - a mental health facility that provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program, utilizing individualized treatment plans with specific attainable goals and objectives that are appropriate both to the patient and to the treatment modality of the program. The facility must be clinically supervised by a *Doctor of Medicine* who is certified in psychiatry by the *American Board of Psychiatry and Neurology*.

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

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
 - 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.

Residential Treatment Center for Children and Adolescents - a child-care institution that is both of the following:

- Provides residential care and treatment for emotionally disturbed children and adolescents.
- Accredited as a residential treatment center by any of these:
 - *The Council of Accreditation.*
 - *The Joint Commission on Accreditation of Hospitals.*
 - *The American Association of Psychiatric Services for Children.*

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Note that Benefits for Outpatient Prescription Drugs, while presented in Rider format, are not

subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

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.

Serious Mental Illness - the following psychiatric illnesses as defined in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).
- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

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 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.

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 - Covered Health Care Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Telehealth Service - a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service - a health care service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

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 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 members with stable and safe housing and the opportunity to learn how to manage their 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, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

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

We have a process by which we compile and review clinical evidence with respect to certain health 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.

Questions, Complaints and Appeals Amendment

UnitedHealthcare Insurance Company

Because this Amendment reflects changes in requirements of Federal and/or Texas law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Since this Amendment 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*.

As described in this Amendment, the Policy is modified by replacing *Section 6: Questions, Complaints and Appeals* of the *Certificate of Coverage* with the provision below.

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 promptly investigate each complaint. The total time for acknowledgement, investigation and resolution of the complaint will not exceed 30 calendar days after we receive the written complaint.

Complaints concerning an Emergency or denials of continued hospitalization will be investigated and resolved in accordance with the medical immediacy of the case, and will not exceed one business day from receipt of the complaint.

We will not engage in any retaliatory action against any Covered Person, Physician or provider. We will not retaliate for any reason including, cancellation of coverage or a provider contract, or refusal to renew coverage or a provider contract because the Covered Person, Physician, provider or person acting on behalf of the Covered Person has filed a complaint against the Policy or has appealed a decision.

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.

Prior Authorization

Prior authorization, included within the pre-service request, is a request to us for proposed services that will result in one of the following:

- A pre-authorization;
- A confirmation of receipt of your request, when there are no clinical issues; or
- An Adverse Determination.

If you receive an Adverse Determination in response to your request for prior authorization of services, you may appeal the decision. Please refer to *Procedures for Appealing an Adverse Determination* below.

For procedures associated with urgent requests for prior authorization of services, see *Urgent Appeals that Require Immediate Action* below.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination, Non-Clinical Benefit Determination or a rescission of coverage determination, you can contact us orally or 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. The appeals process will be completed no later than 30 days after the written request is received.

If an appeal is upheld, within 10 working days of the appeal denial, the appeal may be reviewed by a Physician who is of the same specialty as the health care provider who would typically manage the medical condition, procedure, or treatment when the treating Physician certifies in writing there is good cause for the additional review. The specialty review will be completed within 15 working days from receipt of the request.

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 for you to receive services is between you and your Physician.

Adverse Determinations

An Adverse Determination is a decision that is made by us or our utilization review agent that the health care services furnished or proposed to be furnished to a Covered Person are:

- Not Medically Necessary or appropriate.
- Experimental or Investigational Services.

Adverse Determination does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is Medically Necessary. A complete definition of Adverse Determination is contained in *Section 9: Defined Terms*.

Notice of Adverse Determinations

A utilization review agent shall provide notice of an Adverse Determination as follows:

- With respect to a patient who is hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the Adverse Determination;
- With respect to a patient who is not hospitalized at the time of the Adverse Determination, within three working days in writing to the provider of record and the patient; or
- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating Physician or other health care provider, notice will be provided to the treating Physician or other health care provider no later than one hour after the time of the request.

A utilization review agent shall provide notice of an Adverse Determination for a concurrent review of the provision of the prescription drug or intravenous infusions for which the patient is receiving health benefits under this Policy no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued.

Procedures for Appealing an Adverse Determination

If you, your designated representative or your provider of record receive an Adverse Determination in response to a claim or a request for prior authorization of services, you, your designated representative or your provider of record may appeal the Adverse Determination orally or in writing.

If you, your designated representative or your provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your provider of record a one-page appeal form.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

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 notify you of the decision by the end of the next business day following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

Expedited Appeal for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, Prescription Drugs or intravenous infusions will include a review by a health care provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but will be followed with a letter within three working days of the initial telephonic or electronic notification.

Federal External Review Program

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

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

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

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

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IROs* that have agreed to perform such reviews. There are two types of external reviews available:

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

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating the assignment of claims among the *IROs* or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you

receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

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

Expedited External Review

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

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

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

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

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

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IROs*. We will provide all required documents and information we used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

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

You may call us at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read 'W. J. Golden', with a stylized, flowing script.

William J Golden, President

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products - Outpatient* in your *Certificate of Coverage*, regardless of tier placement.

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

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

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.

- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject 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 prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

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

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

- For urgent step therapy exception requests, a review will be completed within 24 hours once all the information needed to process the request has been received.

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

What Do You Pay?

We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table.

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

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
<p>Co-payment</p> <p>Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount.</p> <p>Co-insurance</p> <p>Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.</p> <p>Co-payment and Co-insurance</p> <p>Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.</p>

Payment Term And Description	Amounts
<p>number on your ID card.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Co-payment/Co-insurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills.</p> <p>Prescription Drug Products Prescribed by a Specialist: You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>NOTE: We may periodically change the placement of a Prescription Drug Product among the tiers or remove a Prescription Drug Product from our Prescription Drug List, based on the Prescription Drug List (PDL) Management Committee's periodic review and decisions. These changes will occur no more often than annually on the Policy anniversary date. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for</p>	

Payment Term And Description	Amounts
<p>the most up-to-date tier status.</p> <p>Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.</p>	

Benefit Information

<p>The amounts you are required to pay as shown below in the <i>Outpatient Prescription Drug Schedule of Benefits</i> are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.</p>	
<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay?</p> <p>This May Include a Co-payment, Co-insurance or Both</p>
<p>Specialty Prescription Drug Products</p>	
<p>The following supply limits apply.</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the <i>Smart Fill Program</i>. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p> <p>If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement.</p> <p>Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$10.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$35.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$50.00 per Prescription Order or Refill.</p> <p>Out-of-Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$10.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$35.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$50.00 per Prescription Order or Refill.</p>
<p>Prescription Drugs from a Retail Network Pharmacy</p>	
<p>The following supply limits apply:</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described below. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p>	<p>Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$10.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$35.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$50.00 per Prescription Order or Refill.</p>
Prescription Drugs from a Retail Out-of-Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described below. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$10.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$35.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$50.00 per</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p>pay a Co-payment and/or Co-insurance for each cycle supplied.</p> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p>	<p>Prescription Order or Refill.</p>
<p>Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>. <p>We may allow a 31-day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Co-payment and/or Co-insurance you would pay at a retail Network Pharmacy. You may find out whether a 31-day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For up to a 90-day supply, you pay:</p> <p>For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$20.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$70.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$100.00 per Prescription Order or Refill.</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p>You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-payment and/or Co-insurance for any Prescription Orders or Refills sent to the mail order pharmacy or Preferred 90 Day Retail Network Pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

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

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

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

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

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read 'W. J. Golden', with a stylized, flowing script.

William J Golden, 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 change the placement of a Prescription Drug Product among the tiers or remove a Prescription Drug Product from our Prescription Drug List. These changes will occur no more often than annually on the Policy anniversary date. We will provide a 60-day written notice prior to the effective date of any change. To determine whether a specific drug is included under the drug formulary, please contact us at www.myuhc.com or the telephone number on your ID card.

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 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.

Continuation of Prescription Drug Coverage

We will continue to provide Network Benefits for any Prescription Drug Product that has been approved or covered under the Policy for a medical condition or Mental Illness, regardless of whether the drug has been removed from the Prescription Drug List before the Policy renewal date. Your Physician or other health care provider with authorization to prescribe a drug may prescribe an alternative drug if the Prescription Drug Product is covered under the Policy and if it is medically appropriate.

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the

Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Specialty Pharmacy Program

If you require certain Specialty Prescription Drug Products, we may direct you to pharmacies with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to such pharmacies and you choose not to obtain your Specialty Prescription Drug Product from one of these pharmacies, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

Smart Fill Program - Split Fill

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

Smart Fill Program - 90 Day Supply

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

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide 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. We do not pass these rebates on to you, nor are they taken into account in determining your Co-payments 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.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. You may access information on these procedures 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 Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist

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

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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 Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

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

Prescription Eye Drops

In accordance with Texas law, refill of prescription eye drops are covered if the enrollee timely pays at the point of sale the maximum amount allowed and:

- The original prescription states that additional quantities of the eye drops are needed;
- The refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and
- The refill is dispensed on or before the last day of the prescribed dosage period and;
 - Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
 - Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
 - Not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

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

Prescription Drugs from a Retail Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail out-of-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

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

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

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will apply to any off-label drug that is excluded from coverage under this Rider as well as any drug that the *U.S. Food and Drug Administration (FDA)* has determined to be contraindicated for the treatment of the disease or condition. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or Life-Threatening Disease or Condition if the drug is both of the following:
 - Has been approved by the *FDA* for at least one indication; and
 - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
 - ♦ A prescription drug reference compendium approved by the *Commissioner* of the *Texas Department of Insurance*.
 - ♦ Substantially accepted peer-reviewed medical literature.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

11. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Treatment for toenail Onychomycosis (toenail fungus).
18. Certain Prescription Drug Products for tobacco cessation.
19. Prescription Drug Products not placed on Tier 1, Tier 2 or Tier 3 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.
20. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
21. 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 will occur no more than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter items for which Benefits are available as described in the *Certificate* under *Diabetes Services* in *Section 1: Covered Health Care Services*. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
22. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
23. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
24. 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. This exclusion does not apply to:
 - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Care Services* of the *Certificate*.
 - Amino acid-based elemental formulas, as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Care Services* of the *Certificate*.

- Formulas for phenylketonuria (PKU) or other heritable diseases.
25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
 26. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
 27. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
 28. Certain Prescription Drug Products that have not been prescribed by a Specialist.
 29. A Prescription Drug Product that contains marijuana, including medical marijuana.
 30. Dental products, including but not limited to prescription fluoride topicals.
 31. 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 will occur no more than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
 32. Diagnostic kits and products.
 33. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

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

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

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.

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.

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 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. These changes will occur no more often than annually on the Policy anniversary date. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your *Certificate*.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

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

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, <https://member.realappeal.com> or at the number shown on your ID card.

UNITEDHEALTHCARE INSURANCE COMPANY



William J Golden, President

Disclosure of Provider Status

UnitedHealthcare Insurance Company

As required by Chapter 1456 of the Texas Insurance Code, this notice provides information regarding the status of providers.

All Physicians and providers at contracted facilities may not be contracted with UnitedHealthcare Insurance Company. Facilities include a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center or other facility that provides health care services.

If you receive health care services at or through a contracted facility and the Physicians or providers who provided that care are not contracted with UnitedHealthcare Insurance Company, the services may be denied or paid at the out-of-Network Benefit level. In those cases, you may be responsible for payment of all or part of the fees for those services.

In these situations, the facility or out-of-Network Physician or provider can balance bill you. Balance billing is the practice of charging the enrollees the amount a health benefit plan does not pay for non-covered or out-of-Network health care services.

Should you have a complaint regarding payments of health care services, you may contact the Texas Department of Insurance Consumer Protection Division at 1-800-252-3439 or email ConsumerProtection@tdi.texas.gov.

Texas Department of Insurance Exclusive Provider Benefit Plan Notice

An exclusive provider benefit plan provides no Benefits for services you receive from out-of-network providers, with specific exceptions as described in your Policy and below.

- You have the right to an adequate Network of preferred providers (known as "network providers"). If you believe that the Network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network Emergency care, your insurer must, in most cases, resolve the nonpreferred provider's bill so that you only have to pay any applicable Co-insurance, Co-payment, and deductible amounts.
- You may obtain a current directory of preferred providers at the following website: [www.myuhc.com] or by calling the telephone number on the back of your ID card for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of Benefits.

Texas Department of Insurance Preferred Provider Benefit Plan Notice

- You have the right to an adequate network of preferred providers (also known as "network providers"). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- You have the right, in most cases, to obtain estimates in advance:
 - from out-of-network providers of what they will charge for their services; and
 - from your insurer of what it will pay for the services.
- You may obtain a current directory of preferred providers at the following website: www.myuhc.com or by calling the number on the back of your ID card for assistance in finding available preferred providers.
- If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer.
- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon, including the amount unpaid by the administrator or insurer, is greater than \$500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.
- If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

TEXAS NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain benefits provided under your Policy.

Please note that the benefits specified below are subject to all terms, conditions, exclusions and limitations stated in your Policy, including, but not limited to, any applicable deductible amounts, coinsurance provisions, notification requirements, copayment amounts and dollar limits.

Examinations for Detection of Prostate Cancer

Benefits are provided for each male Texas resident who is a covered person for an annual medically recognized diagnostic examination for the detection of prostate cancer. Covered expenses include:

- A. A physical examination for the detection of prostate cancer; and
- B. A prostate-specific antigen test for each male covered person who is
 - 1. at least 50 years of age; or
 - 2. at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, you may contact us at www.myuhc.com or the telephone number on your ID card.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- A. 48 hours following an uncomplicated vaginal delivery, and
- B. 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to give birth in a hospital or other health care facility or remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not:

- A. Modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
- B. Offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
- C. Refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
- D. Reduce payments or reimbursements below the usual and customary rate; or

- E. Penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, you may contact us at www.myuhc.com or the telephone number on your ID card.

Mastectomy or Lymph Node Dissection

Benefits are covered under your health insurance Policy for covered expenses related to mastectomy following diagnosis of breast cancer for:

- A. Reconstruction of the breast on which the mastectomy has been performed;
- B. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- C. Prostheses and treatment of physical complication, including lymphedemas.

If, due to treatment of breast cancer, any female Texas resident who is a covered person under your Policy has either a mastectomy or a lymph node dissection, the Policy will provide coverage for inpatient care for a minimum of:

- A. 48 hours following a mastectomy; and
- B. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not:

- A. Deny any covered person's eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
- B. Provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
- C. Reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or
- D. Provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, you may contact us at www.myuhc.com or the telephone number on your ID card.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of ovarian and cervical cancer.

Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, you may contact us at www.myuhc.com or the telephone number on your ID card.

Testing for the detection of Colorectal Cancer

Benefits are provided under your health insurance Policy for covered expenses for colorectal cancer screening.

For each covered person under your Policy who is 50 years of age or older and at normal risk for developing colon cancer, your Policy will include the following as covered expenses:

- A. Charges incurred for the following screening procedures:
 - 1. A fecal occult blood test, limited to one per year; and
 - 2. A flexible sigmoidoscopy, limited to one every five years; or
- B. Charges incurred for a colonoscopy, limited to one every ten years.

If any person covered by this plan has questions concerning the above, you may contact us at www.myuhc.com or the telephone number on your ID card.

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 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.

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

(Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. توجه: اگر زبان شما فارسی

تماس بگیرید. 1-866-633-2446

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

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ(Khmer)សេវាជំនួយភាសាដោយឥតគិតថ្លៃ
គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-633-2446 ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan
bayadna, ket sidadaan para kenyam. 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 kohjì' 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.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા
વનિા મૂલ્યે પૂરાપૂર્ય છે.

કૃપા કરી 1-866-633-2446 પર કોલ કરો. TTY 711

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 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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 under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

Ambulatory patient services; emergency services; hospitalization; laboratory services; maternity and newborn care; mental health care and substance-related and addictive disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and long term disease management; and pediatric services, including oral and vision care.
- On or before the first day of the first plan year beginning on or after September 23, 2010, the group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.
- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:
 - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000.
 - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1,250,000.
 - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2,000,000.

Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. As of September 23, 2010, if you have a grandfathered plan the group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). For plan years beginning January 1, 2014 and beyond, grandfathered plans are required to cover dependents up to age 26, regardless of their eligibility for other employer sponsored coverage.

On or before the first day of the first plan year beginning on or after September 23, 2010, the group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, Co-insurance or Co-payment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, Co-insurance or Co-payment, 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*.
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
 - The individual performs an act, practice or omission that constitutes fraud.
 - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
 - Direct access to OB/GYN care without a referral or authorization requirement.
 - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
 - Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (Co-payments/Co-insurance) will be the same as would be applied to care received from in-network providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered persons participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The first denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will take place as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the first denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the first denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Call UnitedHealthcare at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also call the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>.

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

If your plan includes coverage for Mental Health Care or Substance-Related and Addictive Disorder Services, the following applies:

Mental Health Care/Substance-Related and Addictive Disorder Services Parity

Effective for non-grandfathered small group Policies that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Care Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Care Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for Co-insurance and Co-payments for mental health and substance-related and addictive disorder conditions must be no more restrictive than those Co-insurance and Co-payment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance-related and addictive disorder benefits. Based upon the results of that testing, it is possible that Co-insurance or Co-payments that apply to mental health conditions and substance-related and addictive disorder conditions in your benefit plan may be reduced.

Effective for grandfathered small group Policies that are new or renewing on or after July 1, 2010, Benefits for mental health care conditions and substance-related and addictive disorder conditions that are Covered Health Care Services under the Policy will be revised to align prior authorization requirements and excluded services listed in your *Certificate* with Benefits for other medical conditions.

Effective for grandfathered and non-grandfathered large group Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health care conditions and substance-related and addictive disorder conditions that are Covered Health Care Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Care Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for Co-insurance and Co-payments for mental health care and substance-related and addictive disorder conditions must be no more restrictive than those Co-

insurance and Co-payment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health care and substance-related and addictive disorder benefits. Based upon the results of that testing, it is possible that Co-insurance or Co-payments that apply to mental health care conditions and substance-related and addictive disorder conditions in your benefit plan may be reduced.

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.

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 15 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 15 days from receipt of a request for appeal of a denied request for Benefits.

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.

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 be 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, 2019:

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 Use or Disclose Information

We must 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 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 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 use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or 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 use or 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.

We may use or 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 use or 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 use or 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 use or 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. "Highly confidential information" may include confidential information under 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 where a disclosure of all or part of your health information otherwise could endanger you. 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.

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

- **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 Connecticut, Inc.; 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.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; 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; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, 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 Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; 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 the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthCare 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 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-en or call 1-866-633-2446 or TTY 711.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

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: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.;

gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, 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-en or call 1-866-633-2446 or TTY 711.

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 \$110 a day 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*.

ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: Housing Benefits Plan Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Housing Benefits Plan
8610 King George Drive
Dallas, TX 75235
(615) 225-9477

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 62-1217327

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

Housing Benefits Plan
8610 King George Drive
Dallas, TX 75235
(615) 225-9477

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-0450
860-702-5000

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.

