

UnitedHealthcare Insurance Company

UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

ABC Company

Group Number: XXXXXXXXXX **Health Plan:** BE - M **Prescription Code:** MT
Effective Date: January 1, 2014

Offered and Underwritten by
UnitedHealthcare Insurance Company

Riders, Amendments, and Notices
begin immediately following the last page
of the Certificate of Coverage

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

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

Changes to the Document

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

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

Other Information You Should Have

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

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

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

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

Introduction to Your Certificate

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

How to Use this Document

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

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

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

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

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

Information about Defined Terms

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

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

Don't Hesitate to Contact Us

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

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

Your Enrolling Group may require you to pay your share of any required premium to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

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

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*. Examples of the portion of the cost that you may be responsible for paying are Copayments, Coinsurance, and Annual Deductibles.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

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

Pay Your Share

You must pay a Copayment and/or Coinsurance and/or Annual Deductible for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment, Coinsurance and Annual Deductible amounts are listed in the *Schedule of Benefits*. When you receive care from a non-Network provider, you must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

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

Show Your ID Card

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

Non-Network Services - File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, 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 participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

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

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

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

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

1. Ambulance Services

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

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

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

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip and knees.
- Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

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

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any 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)*.
 - *Department of Defense (DOD)*.
 - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

3. Complementary and Alternative Medicine

Complementary and alternative medicine, limited to the following services:

- Acupuncture. Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:
 - Doctor of Medicine.
 - Doctor of Osteopathy.
 - Chiropractor.
 - Acupuncturist.
- Manipulative services.
- Services provided by a Naturepathic Doctor (ND).

4. Congenital Heart Disease Surgeries

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

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

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

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

5. Dental Services - Accident Only

Dental services when all of the following are true:

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

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

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

- Treatment is started within three months of the accident, 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.

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

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

6. Diabetes Services

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

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

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

Diabetic Self-Management Items

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

7. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

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

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces and other rigid or semi-rigid devices (orthotics) that support a weak or deformed leg, foot, arm, hand, back or neck or that restrict or eliminate motion in a diseased or injured leg, foot, arm, hand, back or neck and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

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

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

Benefits are available for repairs and replacement, except that:

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

Benefits are available for repairs and replacement of orthotic devices which are determined by the Covered

Person's Physician to be medically necessary in order to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

8. Emergency Health Services - Outpatient

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

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

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

9. Hearing Aids

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

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

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

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

10. Home Health Care

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

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

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

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

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

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

11. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

12. Hospital - Inpatient Stay

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

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

13. Lab, X-Ray and Diagnostics - Outpatient

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

- Lab and radiology/X-ray.
- Mammography. Benefits for screening or diagnostic purposes include:
 - A mammogram in symptomatic or high-risk women at any time upon referral of the woman's health care provider.
 - A mammogram every year for women age 40 and over, with or without referral from the woman's health care provider.

Benefits under this section include:

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

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

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

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

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

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

Benefits under this section include:

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

15. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

16. Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- 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 psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available as described under *Pervasive Developmental Disorder* below.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

17. Ostomy Supplies

Benefits for ostomy supplies are those supplies that are listed as covered services in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent consistent with this section.

18. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home, including orally administered anti-cancer medication used to kill or slow the growth of cancerous cells.

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

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

19. Physician Fees for Surgical and Medical Services

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

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 under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

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

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

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

Benefits under this section include allergy injections.

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

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

21. Pregnancy - Maternity Services

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

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

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

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

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

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

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*, including colorectal cancer screening examinations and laboratory tests.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including the Human Papilloma virus (HPV) vaccine.
- 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 breast cancer screening and cervical cancer screening.

Screening mammography to include:

- A mammogram in symptomatic or high-risk women at any time upon referral of the woman's health care provider.
- A mammogram every year for women age 40 and over, with or without referral from the woman's health care provider.
- With respect to men, prostate cancer screening.

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 and lymphedema stockings for the arm.

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

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

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

Benefits are available for repairs and replacement, except that:

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

24. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with 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 a Covered Person 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 include maxillofacial prosthetic services necessary to restore head and facial structures that cannot be replaced by living tissue and are defective because of disease, trauma or birth and developmental deformities when performed for any of the following purposes:

- Controlling or eliminating infection.
- Controlling or eliminating pain.

Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures to improve on the normal range of conditions.

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

25. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- 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 under this

section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

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

Please note that we will pay Benefits for speech therapy 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 Disorders or Pervasive Developmental Disorder in Covered Persons under age 18. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

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 and endoscopy.

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

Benefits under this section include:

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

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

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 initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

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

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

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

28. Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

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

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

29. Surgery - Outpatient

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

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

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

Benefits under this section include:

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

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 and radiation oncology.

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

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

Benefits under this section include:

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

31. Transplantation Services

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

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

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

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

A 12 month exclusion period will apply to all Subscribers enrolling for the first time in the Health Plan for all covered transplant services. The exclusion period will be reduced or eliminated based on prior Continuous Creditable Coverage, which must be continuous with no lapse greater than sixty-three (63) days. Every month of Continuous Creditable Coverage will reduce the 12-month exclusion period by one month. Credit for prior Continuous Creditable Coverage will be given if transplant services were covered under the prior Continuous Creditable Coverage, without regard to the level or use of coverage in the prior plan. Continuous Creditable Coverage must be continuous with no lapse greater than 63 days. Prior coverage credit toward the Exclusion Period is applied on the basis of elapsed time in the prior coverage.

For example, given a 12-month Exclusion Period and the individual had Continuous Creditable Coverage for six 6 months, the applicable Exclusion Period would be 6 months. Every month of applicable Continuous Creditable Coverage will reduce the 12-month Exclusion Period by one month. This exclusion does not apply to Covered Persons under age 19.

We will waive the transplant Benefit Exclusion Period if the transplant is needed as a direct result of:

- A congenital disease or anomaly of a child who has been covered through us since birth; or
- A congenital disease or anomaly of a child who has been covered through us since placement for adoption with the eligible Subscriber.

32. Urgent Care Center Services

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

33. Vision Examinations

Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By Oregon Law

34. Cochlear Implants

Cochlear implants (including bilateral cochlear implants) and Covered Health Services required for implantation when provided by a Physician.

35. Elemental Enteral Formula

Nonprescription elemental enteral formula for home use when all of the following are true:

- The formula is Medically Necessary for the treatment of severe intestinal malabsorption as determined by a Physician.
- A Physician has issued a written order for the formula.
- The formula comprises the sole source, or an essential source, of nutrition.

36. Inborn Errors of Metabolism

Benefits for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist (including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues).

Covered Health Services include diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to:

- Clinical visits.
- Biochemical analysis.
- Benefits for "Medical Foods" used in the treatment of such disorders when provided under the direction of a Physician. For the purposes of this Benefit, "Medical Foods" means foods that are formulated to be consumed or administered enterally for the medical and nutritional management of patients with inborn errors of metabolism.

37. Pervasive Developmental Disorder

Medical services, including physical, occupational, and speech therapy, for Covered Persons under 18 years of age who have been diagnosed with a Pervasive Developmental Disorder when such services are Medically Necessary as determined by the Covered Person's Physician and are not otherwise excluded under *Section 2: Exclusions and Limitations*.

38. Telemedical Services

Coverage is provided for "Telemedical" services the same as other Covered Health Services.

For purposes of this Benefit, "telemedical" is the delivery of medical services and diagnosis, through two-way video communication that allows a health professional to interact with a patient who is at an originating site. An originating site for telemedical services includes but is not limited to:

- Hospital.
- Rural health clinic.
- Federally qualified health center.
- Physician's office.
- Community mental health center.

- Skilled nursing facility.
- Renal dialysis center.
- Site where public health services are provided.

39. Tobacco Use Cessation

Coverage is provided for covered persons fifteen years old or older for tobacco use cessation programs including both educational and medical treatments to help a person overcome nicotine addiction. Qualifying programs must be recommended by a Physician who follows the *United States Public Health Service guidelines*.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

A. Alternative Treatments

1. Acupressure
2. Aromatherapy.
3. Hypnotism.
4. Rolfing.
5. Massage therapy.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*, other than those specifically stated as a Covered Health Service under *Complementary and Alternative Medicine* above. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

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

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

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.
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 specifically as safety items or to affect performance in sports-related activities.
2. Cranial banding.
3. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
4. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill, except for orally administered anti-cancer medication used to kill or slow the growth of cancerous cells.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
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 consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

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 prescription drugs which have not yet been approved by the Food and Drug Administration if the prescribed drug has been recognized as safe and effective for treatment of a particular indication in one or more of the following:

- In publications that the Health Resources Commission determines to be equivalent to:
 - ◆ *The American Hospital Formulary Service Drug Information.*
 - ◆ *Drug Facts and Comparisons (Lippincott-Raven Publishers).*
 - ◆ *The United States Pharmacopoeia Dispensing Information, Volume 1.*
 - ◆ Other publications that have been identified by the *United States Secretary of Health and Human Services* as authoritative.
- In the majority of relevant peer reviewed medical literature.
- By the *United States Secretary of Health and Human Services.*

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

F. Foot Care

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

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

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.

7. Arch supports, except as required under DME.

G. Medical Supplies

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

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

Benefits for diabetic supplies are described under *Diabetes Services* in *Section 1: Covered Health Services*.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
5. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
6. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
8. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.

- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

I. Neurobiological Disorders - Autism Spectrum Disorders

Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
3. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
5. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.
6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
7. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.
8. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

J. Nutrition

1. Individual and group nutritional counseling, except that Benefits include education by a certified diabetic educator as described under *Diabetes Services* in *Section 1: Covered Health Services*. This exclusion also does not apply to medical nutritional education services that are provided 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 an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits described under *Elemental Enteral Formula* or *Inborn Errors of Metabolism* in *Section 1: Covered Health Services*.
3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

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.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - 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 initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs 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. Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:
 - The date you have had Continuous Creditable Coverage for 6 months.
 - The date you have had Continuous Creditable Coverage for 12 months if you are a Late Enrollee.

This exclusion does not apply to Covered Persons under age 19.

N. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy 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 condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, Autism Spectrum Disorders, or Pervasive Developmental Disorder in Covered Persons under age 18.
6. Psychosurgery.
7. Sex transformation operations and related services.
8. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.

10. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
14. In vitro fertilization regardless of the reason for treatment.

O. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

P. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. 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.

Q. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

R. Substance Use Disorders

Exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
3. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

S. Transplants

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

T. Travel

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

U. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic 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 that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.

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

V. Vision and Hearing

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

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

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

W. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ◆ Medically Necessary.
 - ◆ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ◆ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.

7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
8. Autopsy.
9. Foreign language and sign language services.
10. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

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

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

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

Eligible Persons must reside within the United States.

If both spouses are Eligible Persons of the Enrolling 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 actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling 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 the limiting age. 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.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Persons

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

Adding New Dependents

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

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

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

For a Dependent child by reason of birth, adoption or placement for adoption, coverage takes effect on the date of birth, adoption or placement for adoption and continues for 31 days, even if the Subscriber fails to notify us. In order to continue coverage beyond the initial 31 days, we must receive the completed enrollment form along with payment for the entire period following the birth, adoption or placement for adoption.

Special Enrollment Period

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

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

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

- Birth.

- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
 - 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 if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For a Dependent child by reason of birth, adoption or placement for adoption, coverage takes effect on the date of birth, adoption or placement for adoption and continues for 31 days, even if the Subscriber fails to notify us. In order to continue coverage beyond the initial 31 days, we must receive the completed enrollment form along with payment for the entire period following the birth, adoption or placement for adoption.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. 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.

Late Enrollees

A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period, Open Enrollment Period, or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

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

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

When the Policy terminates and is not replaced, we will send written notice to the Enrolling Group of the termination, not less than 10 days after the date the Policy terminates, explaining the rights to continuation coverage under federal and state law and portability coverage required under Oregon law. The Enrolling Group is responsible for giving you that information.

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Other Events Ending Your Coverage

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

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

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, 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. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff.

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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

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

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise 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 chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, 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 an Inpatient Stay

If you are an inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility at the time the Policy is terminated and immediately replaced by coverage under a policy issued by another carrier, your Benefits will be temporarily extended. Benefits will be extended only for the treatment of the condition that has caused the Inpatient Stay.

Benefits will be extended until the earliest of the following dates.

- The date you are discharged from the Inpatient Stay.
- The date you reach any maximum Benefit limit that applies.

These extended Benefits are subject to all terms, conditions, limitations and exclusions of the Policy that is in effect on the day immediately prior to the date coverage would otherwise end.

Continuation of Coverage

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

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

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

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

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails

to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

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

Continuation Coverage under State Law upon Termination of Employment or Loss of Dependent Status

Eligibility

A Covered Person who loses coverage under the Policy due to termination of the Subscriber's employment or loss of eligibility as a Dependent may continue coverage for themselves and for their Enrolled Dependents. Continuation coverage will be offered only to a Covered Person who was insured under the Policy for at least 3 continuous months prior to termination of the Subscriber's employment or the date the Covered Person ceased to be an eligible Dependent.

Continuation coverage is not available to a Covered Person who is eligible for either of the following:

- Federal Medicare coverage.
- Coverage under any other hospital or medical expenses program which was not covering the Covered Person immediately before termination of the Subscriber's employment or eligible Dependent status.

If a Covered Person is eligible for continuation coverage under the *Continuation Coverage under State Law for Surviving, Divorced or Separated Spouses Age 55 and Older* provision described below, he or she will not be eligible for continuation coverage under this provision.

Notice Regarding Continuation Coverage

The Enrolling Group must provide written notice to each Covered Person enrolled under the Policy of the continuation coverage available to Covered Persons under this provision. Notice to the Subscriber will be deemed notice to all Covered Persons.

Payment of Premium

The Subscriber, spouse or eligible Dependent who requests continuation coverage under this provision must pay the Premiums for themselves and any Enrolled Dependents on a monthly basis. Premiums will be due on the same date the Enrolling Group's Policy Charge is due.

Enrollment

A Covered Person who wishes to continue coverage under this provision must request continuation in writing not later than 10 days after the later of the following:

- The date on which employment or coverage under the Policy terminated.
- The date on which the Enrolling Group gave the Covered Person notice of the right to continue coverage.

Under no circumstances may the Covered Person make a request for continuation more than 31 days after the date their employment terminated or coverage under the Policy terminated.

Termination of Coverage

The right to continuation coverage will terminate on the earliest of any of the following:

- The date Premiums are not paid when due, including any grace period allowed under the Policy.
- Nine months from the date coverage would have ended because of termination of employment or loss of Dependent status.
- The date that the Policy is terminated as to all Subscribers under the group except that if a different group policy is made available to all Subscribers of the group, the legally separated, divorced or surviving spouse will be eligible for continuation coverage as if the original Policy had not been terminated.
- The date on which the person becomes insured under any other group health plan.
- The date on which the person becomes eligible for federal Medicare coverage.

Continuation Coverage under State Law for Surviving, Divorced, or Separated Spouses Age 55 and Older

The Subscriber's surviving, divorced or legally separated spouse may continue coverage under the Policy for themselves and any Enrolled Dependents if either of the following apply:

- The spouse and the Dependent children were covered under the Policy and lost coverage because of the death of the Subscriber, and the spouse was 55 years of age or older at the time of the death of the Subscriber.
- The spouse and Dependent children were covered under the Policy and lost coverage because of the divorce or legal separation of the spouse and the Subscriber, and the spouse was 55 years of age or older at the time of the divorce or legal separation.

In order to obtain continuation coverage under this provision, the legally separated or divorced spouse must notify the Enrolling Group of the legal separation or divorce within 60 days of the separation or the entry of a decree of dissolution of marriage. The Enrolling Group's plan administrator must notify the spouse of the right to continuation under this provision within 14 days of the date the plan administrator receives notice of the separation or divorce. The plan administrator will provide the spouse with an election form for continuation coverage and a statement of the periodic Premiums to be charged for the continuation coverage. The spouse must return the continuation coverage election form with any applicable Premiums to the Enrolling Group's plan administrator within 60 days of the date the administrator mailed the notice. If the spouse fails to comply with the procedures provided in this provision, the spouse will lose all rights to continuation of benefits under this provision.

In the event of death of the Subscriber, the Enrolling Group shall provide the plan administrator written notice of the death and the mailing address of the surviving spouse.

The spouse must submit the election form for continuation coverage to the plan administrator within 30 days of the date the notice of election form was first mailed to the spouse.

A spouse who requests continuation coverage under this subsection must pay the required Premium for the spouse and for any Dependent children, on a monthly basis on the same date required of the Enrolling Group. The surviving, divorced or separated spouse of a Subscriber is not entitled to continuation coverage, or else continuation coverage will terminate if any of the following apply:

- The failure to pay Premium when due, including any grace period allowed under the Policy.
- The date that the Policy is terminated as to all Subscribers under the group except that if a different group policy is made available to all Subscribers of the group, the legally separated, divorced or surviving spouse shall be eligible for continuation coverage as if the original Policy has been terminated.
- The date in which the legally separated, divorced or surviving spouse becomes insured under any other group health plan.
- The date on which the legally separated, divorced or surviving spouse remarries and becomes covered under another group health plan.
- The date in which the legally separated, divorced or surviving spouse becomes eligible for federal Medicare coverage.

Continuation Coverage under State Law upon Termination of Employment Due to a Work-Related Injury or Sickness

A Subscriber who incurs an injury or illness, for which a workers' compensation claim is filed, may continue coverage under the Policy. For continuation to occur, the Subscriber must pay the entire Premium for him or herself and for all Enrolled Dependents on a timely basis. The Subscriber may maintain coverage until whichever of the following events first occurs:

- The Subscriber takes full-time employment with another employer.
- Six months from the date that the Subscriber first makes payment under this section.
- Failure to pay Premium when due, including any grace period allowed under the Policy.
- The date that the Policy is terminated as to all Subscribers under the group except that if a different group policy is made available to all Subscribers of the group, the Subscriber shall be eligible for continuation coverage as if the original Policy has been terminated.

- The date in which the Subscriber becomes insured under any other group health plan.
- The date in which the Subscriber becomes eligible for federal Medicare coverage.

A Subscriber must request continuation coverage in writing within 10 days after the later of the date on which employment is terminated, or the date on which the Enrolling Group gives the Subscriber notice of the right to continue coverage under this provision. The Subscriber may not make a request for continuation more than 31 days after the date coverage terminated.

Continuation Coverage under State Law for Strikes or Lockouts

Should the Premiums be paid by the Enrolling Group under the terms of a collective bargaining agreement and there is a cessation of work by the Subscriber due to a strike or lockout, then the Benefits offered under the Policy shall continue in effect provided that the Subscriber continues to pay the amount due from the Enrolling Group in accordance with the terms of the Policy. The union that represents the Subscriber will be responsible for collecting the Premiums and paying them to use on or before the date the Premiums are due. The amount of the Premium to be paid by such Subscriber shall be equal to the amount set forth in the Policy for the category in which the Subscriber and his or her Enrolled Dependents belong, subject to a maximum increase of 20% to pay for our increased administrative costs. Nothing in this section shall be deemed to limit any right we may have in accordance with the terms of the Policy to increase or decrease the Premiums. Coverage under the section shall continue only until any one of the following occurs:

- The date less than 75 percent of the Subscribers continue coverage.
- Six months after cessation of work by the Subscriber.
- The date the Subscriber takes full-time employment with another employer.
- The date the strike or lockout ends, and the Policy returns to regular coverage.
- The date Premiums are not received in a timely fashion.

If the Premiums due under the Policy are unpaid at the date of cessation of work, and had become due prior to such cessation of work, continuation coverage described under this Section is contingent upon payment of applicable Premiums prior to the next Premium due under this Policy.

Portability Coverage

Individual Portability Contract

Upon termination of a Covered Person's coverage under the Policy, including termination because a Covered Person is no longer eligible for benefits under COBRA, the Covered Person may apply for and receive the individual Prevailing or Low Cost Portability Plans.

Coverage on behalf of the Covered Person and his or her Dependents will be subject to the terms, conditions and limitations of this section and subsections. The terms and condition of Portability Plan Coverage are set forth in the *UnitedHealthCare Insurance Company Portability Health Benefit Plan*, copies of which will be provided directly to the Covered Person losing group coverage, for any reason other than group replacement of coverage, within 10 days following the date of any administrative action taken by us to initiate or document the loss of coverage. The Portability Health Benefit Plan will cover the eligible Subscriber and all Enrolled Dependents who were covered under the Policy on the date of their termination under the Policy, if eligible.

Eligibility requirements for either the Prevailing Portability Plan or the Low Cost Portability Plan are as follows:

- Eligible individuals are those Subscribers who have been continuously covered for 180 days or more under one or more Oregon employer group plans or 18 months of prior health insurance coverage and the most recent coverage was in an Oregon-based group health benefit plan. Dependents are not required to have continuous group coverage for 180 days, but must meet all other eligibility requirements set forth in the Policy. Individuals having less than 180 days or Oregon coverage may be eligible under the federal *Health Insurance Portability and Accountability Act (HIPAA)* for coverage in a Portability Plan.
- Eligible individuals may enroll in Portability Plans before, during or at the end of their COBRA or Oregon continuation coverage.
- Eligible individuals who leave the Policy and apply for Portability coverage must do so within 63 days of losing their group coverage.

- Eligible individuals must be a resident of the State of Oregon at the time of application for a Portability Plan and remain an Oregon resident.
- Eligible individuals may not enroll in a Portability Plan if they were eligible for federal Medicare prior to the eligibility for a Portability Plan.

The terms and conditions of Portability Plan coverage are set forth in the Prevailing and Low Cost Portability Benefit Plan Policies, copies of which are available from us upon request.

Dependent Portability Rights

A Dependent spouse who loses eligibility as the result of the death of a Subscriber or divorce from the Subscriber may apply for and receive portability coverage for him or herself and on behalf of any Enrolled Dependent children who also lose their eligibility.

Renewal Portability Rights

Renewal of an individual Portability Plan shall not be allowed if any of the following apply:

- The Covered Person has not paid required Premiums for coverage under the Portability Policy.
- The Covered Person has not complied with Policy provisions regarding renewability.
- We cease to offer any group health benefit plans and written advance notice of that decision is provided to the *Director of the Oregon Department of Consumer and Business Services* and the Covered Person at least 180 days in advance.
- We have determined fraud or misrepresentation by the Covered Person.
- The *Director of the Oregon Department of Consumer and Business Services* has determined that we cannot meet our contractual obligations under the Portability Plan.
- We will give a 90 day notice to the Enrolling Groups and the *Director of Consumer and Business Services* when either of the following applies:
 - All group health benefit plans in the state are discontinued due to our inability to negotiate provider agreements.
 - A single group in a specified service area within the state is discontinued due to our inability to negotiate provider agreements.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

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

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced. 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 insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

Payment of Benefits

You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

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

Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

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

What to Do if You Have a Complaint

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

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

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care. If we adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies, you may appeal that decision pursuant to this process.

How to Request an Appeal or File a Grievance

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you may file a formal Grievance/appeal by contacting us in writing.

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.

Grievance and Appeal Process

What is a Grievance

A "Grievance" is a written complaint submitted by or on behalf of a Covered Person regarding any of the following:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.
- Claims payment, handling or reimbursement for health care services.

Matters pertaining to the contractual relationship between the Covered Person and us.

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

Grievance/Appeals Determinations

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

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

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

- For Grievance/appeals of pre-service requests for Benefits as identified above, the first level Grievance/appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for Grievance/appeal of a denied request for Benefits. If you are not satisfied with the first level Grievance/appeal decision, you have the right to request a second level Grievance/appeal. Your second level Grievance/appeal request must be submitted to us within 60 days from receipt of the first level Grievance/appeal decision. The second level Grievance/appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level Grievance/appeal decision. The request will be reviewed by individuals not involved in the previous review. If you wish to waive this level of review and you meet the criteria for external review, you may proceed directly to external review which is conducted by an independent review organization. In the event of an initial Grievance, we may request an additional 15 days to resolve the issue if before the 30th day, we provide a written notice of the delay to the Covered Person or the Covered Person's authorized representative that includes a specific reason for the delay.
- For Grievance/appeals of post-service claims as identified above, the first level Grievance/appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for Grievance/appeal of a denied claim. If you are not satisfied with the first level Grievance/appeal decision, you have the right to request a second level Grievance/appeal. Your second level Grievance/appeal request must be submitted to us within 60 days from receipt of the first level Grievance/appeal decision. The second level Grievance/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 Grievance/appeal decision. The request will be reviewed by individuals not involved in the previous review. If you wish to waive this level of review and you meet the criteria for external review, you may proceed directly to external review which is conducted by an independent review organization. In the event of an initial Grievance, we may request an additional 15 days to resolve the issue if before the 30th day, we provide a written notice of the delay to the Covered Person or the Covered Person's authorized representative that includes a specific reason for the delay.

Third Level

If you are not satisfied with our decision at the second level review, you may request a third level review by our internal review panel by submitting your request in writing. The request will be reviewed by a panel of individuals not involved in the previous review. If you wish to waive this level of review and you meet the criteria for external review, you may proceed directly to external review which is conducted by an independent review organization.

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

Urgent Grievances/Appeals that Require Immediate Action

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

External Review Program

After you exhaust the Grievance/appeal process, you may request an external review by an *Independent Review Organization (IRO)*. The director of the *Department of Consumer and Business Services* will contract with and appoint the IRO.

External review will be available for a dispute relating to an adverse decision of one or more of the following:

- Whether a course or plan of treatment is medically necessary.
- Whether a course or plan of treatment is an Experimental or Investigational Service.
- Whether a course or plan of treatment that a Covered Person is undergoing is an active course of treatment for purposes of continuity of care.

We will incur all costs of the external review program. You must apply in writing for external review not later than the 180th day after receipt of our final adverse determination. You are eligible for external review only if you have a signed release granting the IRO access to your medical records.

The IRO will establish an expedited review process:

- When the review is expedited, the organization will issue a decision not later than the third day after the date on which you apply to us for an expedited review.
- When a review is not expedited, the organization will issue a decision not later than 30 calendar days after you apply to us for a review.

We agree to be bound by the decision of the IRO.

You have a private right of action against us for damages arising from an adverse decision by us if:

- We are not bound by the decisions of an IRO; and
- We fail to comply with the decision.

Notification of an adverse decision will include:

- Your right to apply for internal and external review.
- A statement whether a decision by an IRO is binding on us and on you.
- Information on filing a complaint with the *Director of Department of Consumer and Business Services*.

You may contact us at the telephone number shown on your ID card for more information on the external review program.

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 based on Oregon regulations and from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

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

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

Definitions

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

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - 1. Plan includes: group 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 means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit

paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

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

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

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

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
 - c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or

covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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

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

Payments Made

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

Right of Recovery

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

When Medicare is Secondary

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

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

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

Our Relationship with Providers and Enrolling Groups

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

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

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

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

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

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

Your Relationship with Providers and Enrolling Groups

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

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

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

Notice

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

Statements by Enrolling Group or Subscriber

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

Incentives to You

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

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 Copayments or Coinsurance.

Interpretation of Benefits

We have the discretion to do all of the following:

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

We may delegate this discretionary 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, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

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

Amendments to the Policy

To the extent permitted by law, we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

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

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

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

Information and Records

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

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

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

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the

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

Limitation of Action

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

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

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

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

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

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

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Autism Spectrum Disorders - a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

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

Calendar Year - January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.

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

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

Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

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

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

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - 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 Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

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

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

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

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

Status as a Dependent will not be affected by the parent's marital status at the time of the child's birth, support and maintenance requirements for tax purposes, or residence requirements.

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

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

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

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

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

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

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

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age, otherwise capable and at least one must be a resident of Oregon.
- They must be mentally competent to consent to contract.
- They must be financially interdependent.

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

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

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

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

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

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

Emergency - a medical condition or symptom resulting from Injury, Sickness or:

- Mental Illness that manifests itself by acute symptoms of sufficient severity including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person or fetus, in the case of a pregnant woman, in serious jeopardy.

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

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

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

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use 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 considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- Life-Threatening Sickness or Condition. 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, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

Health Benefit Plan - any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal *Employee Retirement Income Security Act of 1974*, as amended. Health Benefit Plan does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pursuant to contracts with the federal government, benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

- It has 24-hour nursing services.

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

This definition includes any Hospital owned or operated by the State of Oregon or any community mental health and developmental program operated by the State of Oregon.

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

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

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

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

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

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

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

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

Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.

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

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined solely 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 use disorder, 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 reserve 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 made solely 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 on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

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

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

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

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

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

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

Pervasive Developmental Disorder - a neurological condition that includes Aspergers syndrome, autism, developmental delay, developmental disability or mental retardation. A Pervasive Developmental Disorder does not include mental or nervous conditions, chemical dependency or alcoholism.

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

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

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, nurse practitioner, clinical social worker, physician assistant or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

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

Policy Year - the twelve month period beginning on the Policy effective date.

Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the three month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

Pregnancy - includes all of the following:

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

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

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician.

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

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

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

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

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

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

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

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

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

Small Employer - an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan

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

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

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition* does not mean that treatment of the disorder is a Covered Health Service. Chemical dependency means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

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

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

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

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

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

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

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

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

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.

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

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

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

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

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

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, 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 prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air and ground.
- Clinical trials.
- Cochlear Implants.
- Congenital heart disease surgery.
- Dental services - accidental.
- Diabetes equipment - insulin pumps over \$1,000.
- Durable Medical Equipment over \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Formulas/specialized foods.
- Genetic Testing - BRCA.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Inborn errors or metabolism.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Pervasive Developmental Disorder services.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Surgery - only for the following outpatient surgeries: diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health 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 Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered

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

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health 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 implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</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 Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p><i>Designated Network and Network</i></p> <p>\$1,000 per Covered Person, not to exceed \$3,000 for all Covered Persons in a family.</p> <p><i>Non-Network</i></p> <p>\$2,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family.</p>
Out-of-Pocket Maximum	
<p>The maximum you pay per year for the Annual Deductible or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year.</p> <p>Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. The amount Benefits are reduced if you do not obtain prior authorization as required. 	<p><i>Designated Network and Network</i></p> <p>\$4,500 per Covered Person, not to exceed \$13,500 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p> <p><i>Non-Network</i></p> <p>\$9,000 per Covered Person, not to exceed \$27,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p>

Payment Term And Description	Amounts
<ul style="list-style-type: none"> Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. 	
Copayment	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> The applicable Copayment. The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Coinsurance	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses 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 Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Ambulance Services			
<p>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 prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Emergency Ambulance	<p>Network</p> <p><i>Ground Ambulance:</i></p> <p>80%</p>	Yes	Yes
	<p><i>Air Ambulance:</i></p> <p>80%</p>	Yes	Yes
	<p>Non-Network</p> <p>Same as Network</p>	Same as Network	Same as Network
Non-Emergency Ambulance	<p>Network</p> <p><i>Ground Ambulance:</i></p> <p>80%</p>	Yes	Yes
	<p><i>Air Ambulance:</i></p> <p>80%</p>	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network Same as Network	Same as Network	Same as Network
2. Clinical Trials			
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Depending upon the Covered Health 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 Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
3. Complementary and Alternative Medicine			
Limited to \$1,500 per year. Covered Health Services provided under this section by a Non-Network Physician will be paid as Network Benefits.	Network 100% after you pay a Copayment of \$25 per visit	No	No

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 100% after you pay a Copayment of \$25 per visit	Same as Network	Same as Network

4. Congenital Heart Disease Surgeries

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes

5. Dental Services - Accident Only

Prior Authorization Requirement

For Network and Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Limited to \$3,000 per year. Benefits are further limited to a maximum of \$900 per tooth.	Network 80%	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network
6. Diabetes Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i> .	Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
7. Durable Medical Equipment			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician. The annual limits above do no apply to orthotics that are covered under DME.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
8. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you	Network 80% after you pay a Copayment of \$200 per visit .	Yes, when Benefits are subject to Coinsurance.	No

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.	If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.		
	Non-Network Same as Network	Same as Network	Same as Network
9. Hearing Aids			
<p>For Dependent Children who are: a) under age 18; or b) 18 years of age or older, eligible as a Dependent under the plan and enrolled in an accredited educational institution:</p> <ul style="list-style-type: none"> Limited to \$5,000 in Eligible Expenses every 48 months. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. <p>For all other Covered Persons:</p> <ul style="list-style-type: none"> Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. 	Network 80%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 50%	Yes	Yes
10. Home Health Care			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to 130 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.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
11. Hospice Care			
Prior Authorization Requirement For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network 80%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 50%	Yes	Yes
12. Hospital - Inpatient Stay			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-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>			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
13. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:	Network 80%	Yes	No
	Non-Network 50%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	Network 80%	Yes	No

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 50%	Yes	Yes
14. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
15. Mental Health Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Prior authorization is not required for outpatient Mental Health Services except for those services indicated above.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network <i>Inpatient</i> 80%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<i>Outpatient</i> 100% after you pay a Copayment of \$50 per visit	No	No
	Non-Network <i>Inpatient</i> 50%	Yes	Yes
	<i>Outpatient</i> 50%	Yes	Yes
16. Neurobiological Disorders - Autism Spectrum Disorder Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Prior authorization is not required for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services except for those services indicated above.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network <i>Inpatient</i> 80%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<i>Outpatient</i> 100% after you pay a Copayment of \$50 per visit	No	No
	Non-Network <i>Inpatient</i> 50%	Yes	Yes
	<i>Outpatient</i> 50%	Yes	Yes
17. Ostomy Supplies			
Limited to \$2,500 per year.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
18. Pharmaceutical Products - Outpatient			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
19. Physician Fees for Surgical and Medical Services			
Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
20. Physician’s Office Services - Sickness and Injury			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician’s office: <ul style="list-style-type: none">Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>	Designated Network 100% after you pay a Copayment of \$25 per visit for a Primary Physician office visit or \$25 per visit for a Specialist Physician office visit	No	No

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none">Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. Benefits for services provided by a Naturopathic Physician are included under the Complementary and Alternative Medicine Category above.			
	Network 100% after you pay a Copayment of \$25 per visit for a Primary Physician office visit or \$50 per visit for a Specialist Physician office visit	No	No
	Non-Network 50%	Yes	Yes
21. Pregnancy - Maternity Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>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.</p>			
	Network Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of</i>		

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Benefits except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
	Non-Network Benefits will be the same as those stated under each Covered Health 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			
Physician office services	Network 100%	No	No
	Non-Network Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.
Lab, X-ray or other preventive tests	Network 100%	No	No
	Non-Network Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
23. Prosthetic Devices			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
24. Reconstructive Procedures			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-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).</p>			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
25. Rehabilitation Services - Outpatient Therapy			
<p>Limited per year as follows:</p> <ul style="list-style-type: none"> • 20 visits of physical therapy. • 20 visits of occupational therapy. • 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. 	<p>Network</p> <p>100% after you pay a Copayment of \$25 per visit</p>	No	No
	<p>Non-Network</p> <p>50%</p>	Yes	Yes
26. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	<p>Network</p> <p>80%</p>	Yes	Yes
	<p>Non-Network</p> <p>50%</p>	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-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 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
28. Substance Use Disorder Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Prior authorization is not required for outpatient Substance Use Disorder Services except for those services indicated above.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network <i>Inpatient</i> 80%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<i>Outpatient</i> 100% after you pay a Copayment of \$50 per visit	No	No
	Non-Network <i>Inpatient</i> 50%	Yes	Yes
	<i>Outpatient</i> 50%	Yes	Yes
29. Surgery - Outpatient			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
30. Therapeutic Treatments - Outpatient			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
31. Transplantation Services			
<p>Prior Authorization Requirement</p> <p>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 performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply.</p> <p>For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-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>			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Non-Network Benefits are limited to \$30,000 per transplant.</p> <p>Subject to a 12 month exclusion period with credit for prior Continuous Creditable Coverage.</p>	<p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>32. Urgent Care Center Services</p>			
<p>In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>. Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. 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>. 	<p>Network</p> <p>100% after you pay a Copayment of \$50 per visit</p>	<p>No</p>	<p>No</p>
	<p>Non-Network</p> <p>50%</p>	<p>Yes</p>	<p>Yes</p>

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
33. Vision Examinations			
Limited to 1 exam every 2 years.	Network 100% after you pay a Copayment of \$25 per visit	No	No
	Non-Network Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.
Additional Benefits Required By Oregon Law			
34. Cochlear Implants			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before obtaining a cochlear implant. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
35. Elemental Enteral Formula			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before obtaining elemental enteral formula. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<p>Network</p> <p>80% or as stated under the <i>Outpatient Prescription Drug Rider</i>.</p>	Yes	Yes
	<p>Non-Network</p> <p>50% or as stated under the <i>Outpatient Prescription Drug Rider</i>.</p>	Yes	Yes
36. Inborn Errors of Metabolism			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before receiving services for treatment of inborn errors of metabolism or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
Testing, diagnosing, monitoring, analysis, dietary counseling.	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
Medical foods for the treatment of Inborn Errors of Metabolism.	Network 80% or as stated under the <i>Outpatient Prescription Drug Rider</i> .	Yes	Yes
	Non-Network 50% or as stated under the <i>Outpatient Prescription Drug Rider</i> .	Yes	Yes
37. Pervasive Developmental Disorder			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before receiving services for treatment of a Pervasive Developmental Disorder or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited per year as follows: <ul style="list-style-type: none">• 20 visits of physical therapy.• 20 visits of occupational therapy.• 20 visits of speech therapy.	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
38. Telemedical Services			
	<i>Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
	<i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
39. Tobacco Use Cessation			
Benefits for tobacco use cessation medications are provided under the <i>Outpatient Prescription Drug Rider</i> .	<i>Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
	<i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Designated Network Benefits and Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by state law.

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
 - ◆ 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:
 - o For services other than Pharmaceutical Products, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.
 - o 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, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge, except that certain Eligible Expenses for Mental Health Services and Substance Use Disorder Services are based on 80% of the billed charge.
 - ◆ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

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

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

Provider Network

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

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

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

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

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

Continuity of Care

Continuity of care is a feature of the Policy under which a Covered Person who is receiving care from an individual Network provider is entitled to continue with care with the individual Network provider for a limited period of time after the Network provider is no longer contracted with us to provide Covered Health Services to Covered Persons.

You are entitled to continuity of care as described above if all of the following apply:

- The written agreement for an individual provider has terminated.
- The provider no longer participates in the provider Network.
- We do not cover services when services are provided to Covered Persons by the individual provider or we cover services at a Benefit level below the Benefit level specified in the Policy for non-Network providers.

In order to obtain continuity of care, you must request continuity of care by calling the telephone number on your ID card for *Customer Care*.

You are entitled to continuity of care when you are undergoing a course of treatment that is medically necessary and when both you and the provider agree that it is desirable to maintain continuity of care.

You are not entitled to continuity of care when the written agreement between the individual provider and us ends as a result of one of the following circumstances:

- The written agreement between the individual provider and us has ended because of any of the following:
 - The individual provider has retired.
 - The individual provider died.
 - The individual no longer holds an active license.
 - The individual provider has gone on sabbatical.
 - The individual provider is prevented from continuing to care for patients because of other circumstances.
- The written agreement has terminated in accordance with provisions of the medical services contract relating to quality of care and all contracted appeal rights of the individual provider have been exhausted.

We are not required to provide continuity of care if your coverage under the Policy ends or if the Enrolling Group discontinues the plan under which you are covered.

Except as provided for Pregnancy described below, a Covered Person who is entitled to continuity of care shall receive the care until the earlier of the following dates:

- The day following the date on which the active course of treatment entitling the Covered Person to continuity of care is completed.
- The 120th day after the date we notify you of the termination of the written agreement with the individual provider.

A Covered Person who is undergoing care for Pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the Pregnancy shall receive the care until the later of the following dates:

- The 45th day after the birth.

As long as the Covered Person continues under an active course of treatment, but not later than the 120th day after the date we notify you of the termination of the written agreement with the individual provider.

Designated Facilities and Other Providers

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

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider 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 Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your 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 a non-Network provider.

Limitations on Selection of Providers

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

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

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

Telemedical Services for Diabetes Treatment Amendment

UnitedHealthcare Insurance Company

The Policy is modified as described in this Amendment.

Because 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*.

Section 1: Covered Health Services

Telemedical Services in the Certificate, Section 1: Covered Health Services is replaced with the following:

Telemedical Services

Coverage is provided for "Telemedical" services the same as other Covered Health Services.

For purposes of this Benefit for telemedical health services not related to the treatment of diabetes, "telemedical" means delivered through a two-way video communication that allows a health professional to interact with a patient who is at an originating site. An originating site for telemedical services includes but is not limited to a:

- Hospital.
- Rural health clinic.
- Federally qualified health center.
- Physician's office.
- Community mental health center.
- Skilled nursing facility.
- Renal dialysis center.
- Site where public health services are provided.

For telemedical health services provided in connection with the treatment of diabetes, "telemedical" means delivered through a two-way electronic communication, including but not limited to video, audio, Voice over Internet Protocol or transmission of telemetry, that allows a health professional to interact with a patient, a parent or guardian of a patient or another health professional on a patient's behalf, who is at an originating site. For purposes of this Benefit in connection with the treatment of diabetes, "originating site" means a location where health care services are provided or where the patient is receiving a telemedical health service.

UnitedHealthcare Insurance Company



President

Questions, Complaints and Appeals Amendment

UnitedHealthcare Insurance Company

The Policy is modified as described in this Amendment.

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

Section 6: Questions, Complaints and Appeals

The provision in the Certificate under Section 6: Questions, Complaints and Appeals, is replaced with the following:

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

What to Do if You Have a Question

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

What to Do if You Have a Complaint

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

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

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

You may also seek assistance from or file a complaint with the *Oregon Insurance Division* who can be reached:

- By calling (503) 947-7984 or the toll free message line at (888)877-4894
- By writing to the:
Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE
Salem, OR 97301-3883
- Through the Internet at <http://www.insurance.oregon.gov/cpmsumer/tomake.html>
- By email at cp.ins@state.or.us

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request a Grievance/Appeal

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

A "Grievance" is a request submitted by a Covered Person or an Authorized Representative of a Covered Person, that is:

- In writing, for an internal appeal or an external review; or
- In writing or orally, for an expedited review or an expedited external review; or
- A written complaint submitted by a Covered Person or an Authorized Representative of the Covered Person regarding the:
 - Availability, delivery or quality of a health care service;
 - Claims payment, handling or reimbursement for health care services and, unless the Covered Person has not submitted a request for an internal appeal, the complaint is not disputing an Adverse Benefit Determination; or
 - Matters pertaining to the contractual relationship between a Covered Person and UnitedHealthcare.

Your request for a Grievance/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 Grievance/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.

Grievance/Appeal Process

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

Grievance/Appeals Determinations

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

For procedures associated with urgent requests for Benefits, see *Urgent Grievance/Appeals that Require Immediate Action* below.

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

- Within seven days of receipt of a Grievance/appeal, UnitedHealthcare will send written acknowledgment of receipt to you or your Authorized Representative.
- For Grievance/appeals of pre-service requests for Benefits as identified above, the Grievance/appeal will be conducted and you or your Authorized Representative will be notified of the decision within 30 days from receipt of a request for Grievance/appeal of a denied request for Benefits. We may extend the timeframe to make a determination for an additional 15 days if we provide written notice and the reason for the delay to you or your Authorized Representative within the first 30 days of receipt of the Grievance/appeal.
- For Grievance/appeals of post-service claims as identified above, the Grievance/appeal will be conducted and you or your Authorized Representative will be notified of the decision within 30 days from receipt of a

request for Grievance/appeal of a denied claim. We may extend the timeframe to make a determination for an additional 15 days if we provide written notice and the reason for the delay to you or your Authorized Representative within the first 30 days of receipt of the Grievance/appeal.

You are entitled to receive continued coverage of the disputed health care service or item pending the conclusion of the Grievance/appeal process. However, you will be financially responsible to pay for the disputed health care service or item if UnitedHealthcare's denial is not reversed.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

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

Urgent Grievance/Appeals that Require Immediate Action

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

External Review Program

You have the right to apply for an external review by an Independent Review Organization within 180 days of receipt of UnitedHealthcare's final Adverse Benefit Determination.

If, after exhausting your internal Grievance/appeals, you are not satisfied with the determination made by us, or if we fail to respond to your Grievance/appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

You are eligible to request an external review by an Independent Review Organization (IRO) if the dispute relates to an Adverse Benefit Determination regarding whether a course or plan of treatment is:

- Medically Necessary;
- Experimental or Investigational;
- An active course of treatment for purposes of continuity of care;
- Delivered in an appropriate health care setting and with the appropriate level of care.

You or your Authorized Representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your Authorized Representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within 180 days after the date you received our decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your Authorized Representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal Grievance/appeal.
- A signed release granting the IRO access to your medical records.

UnitedHealthcare will notify the Director of the *Department of Consumer and Business Services* no later than two business days after receipt of the external review request.

The Director of the *Department of Consumer and Business Services* will contract with and appoint the IRO. You may submit additional information to the IRO no later than five business days after you receive notification of the appointment of an IRO, or within 24 hours in the case of an expedited external review.

The IRO will make a decision not later than the 30th day after you applied for external review. Written notification of the decision will be issued by the IRO within five days of the decision date.

UnitedHealthcare will incur all costs of the external review program.

Expedited External Review

An external review will be expedited when:

- The Adverse Benefit Determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the Covered Person received Emergency Health Services and has not been discharged from a health care facility; or
- A provider with an established clinical relationship with the Covered Person certifies in writing and provides supporting documentation that the ordinary timeframe for a standard external review would seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function.

When the review is expedited, the IRO will issue a decision no later than the third day after the date you applied for external review.

Waiving the Grievance/Appeal Process and Proceeding Directly to External Review

For Adverse Benefit Determinations eligible for expedited external review, the Covered Person is not required to complete UnitedHealthcare's internal Grievance/appeal process, including UnitedHealthcare's expedited internal Grievance/appeal process, before requesting an expedited external review. The Covered Person may request an expedited external review before exhausting UnitedHealthcare's Grievance/appeal process and may proceed directly to external review by an IRO.

UnitedHealthcare may choose to waive the Grievance/appeal process at any time for Adverse Benefit Determinations eligible for external review. If UnitedHealthcare waives the Grievance/appeal process, the Grievance/appeal process is deemed to have been exhausted for purposes of qualifying for external review.

A Covered Person is deemed to have exhausted the internal Grievance/appeal process if UnitedHealthcare does not comply with applicable regulations regarding timing of the response to an internal Grievance/appeal.

Binding Nature of the External Review Decision

UnitedHealthcare agrees to be bound by a decision of an IRO and may be penalized by the Department of Consumer and Business Services if it fails to follow the decision of an IRO. You have the right to sue UnitedHealthcare if the IRO's decision is not implemented by UnitedHealthcare.

UnitedHealthcare must comply in a timely manner with a decision by an IRO that reverses, in whole or in part, an Adverse Benefit Determination.

The Covered Person who is the subject of a decision by an IRO has a private right of action against UnitedHealthcare for damages arising from an Adverse Benefit Determination if UnitedHealthcare fails to comply with the IRO's decision.

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

Section 8: General Legal Provisions

The provision in the Certificate under Section 8: General Legal Provisions, Information and Records, is replaced with the following:

Information and Records

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

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

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

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

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

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

The following additional information regarding UnitedHealthcare is available upon request:

- Grievance and Appeals, Annual Summary.
- Utilization Review Policies; Annual Summary.
- Quality Improvement Activities, Annual Summary.
- Results of all publicly available accreditation surveys.
- Health Promotion and Disease Prevention Activities, Annual Summary.
- Provider Network and Accessibility Services; Annual Summary.

Section 9: Defined Terms

The following definitions of Adverse Benefit Determination and Authorized Representative are added to the Certificate under Section 9: Defined Terms:

Adverse Benefit Determination - A denial, reduction or termination of a health care item or service, or UnitedHealthcare's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on UnitedHealthcare's:

- Denial of eligibility for or termination of enrollment in the Policy;
- Rescission or cancellation of this Policy;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual Benefit limit or other limitation on otherwise Covered Health Services;
- Determination that a health care item or service is Experimental, Investigational or not medically necessary, effective or appropriate; or
- Determination that a course or plan of treatment that a Covered Person is undergoing is an active course of treatment for purposes of continuity of care.

Authorized Representative - An individual who by law or by the consent of a Covered Person may act on behalf of the Covered Person.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read "J. Kelly", followed by a horizontal line.

President

Orally Administered Anti-Cancer Medication Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide coverage for orally administered anti-cancer medication used to kill or slow the growth of cancerous cells.

Because 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*.

Section 1: Covered Health Services

Pharmaceutical Products - Outpatient in the Certificate, Section 1: Covered Health Services is replaced with the following:

17. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home, including orally administered anti-cancer medication used to kill or slow the growth of cancerous cells. If the Policy includes an *Outpatient Prescription Drug Rider*, Benefits for orally administered anti-cancer medication will be provided under the prescription drug Benefit.

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

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

Section 2: Exclusions and Limitations

The exclusion for outpatient prescription drugs in the Certificate under Section 2: Exclusions and Limitations, Drugs is replaced with the following:

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill, except for orally administered anti-cancer medication used to kill or slow the growth of cancerous cells if this Policy does not include an *Outpatient Prescription Drug Rider*.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

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 consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read "J. H. [unclear]", written in a cursive style.

President

Primary Physician Amendment

UnitedHealthcare Insurance Company

The Policy is modified as described in this Amendment.

Because 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* and in this Amendment below.

Section 9: Defined Terms

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

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

UnitedHealthcare Insurance Company



President

Dental and Orthodontic Services for Craniofacial Anomalies Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for dental and orthodontic services for treatment of craniofacial anomalies determined to be Medically Necessary to restore function.

Because 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*.

Section 1: Covered Health Services

Reconstructive Procedures in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with 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 a Covered Person 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 include maxillofacial prosthetic services necessary to restore head and facial structures that cannot be replaced by living tissue and are defective because of disease, trauma or birth and developmental deformities when performed for any of the following purposes:

- Controlling or eliminating infection.
- Controlling or eliminating pain.
- Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures to improve on the normal range of conditions.

Benefits include dental and orthodontic services for the treatment of craniofacial anomalies if the services are Medically Necessary to restore function. For purposes of this Benefit, "craniofacial anomaly" means a physical disorder identifiable at birth that affects the bony structures of the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Dental or orthodontic services for developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or for treatment of temporomandibular joint disorder are excluded from coverage.

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

Section 2: Exclusions and Limitations

The exclusions for dental services in the Certificate under Section 2: Exclusions and Limitations, Dental is replaced with the following:

B. Dental

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

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

This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health 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 Services*.

This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

4. Dental braces (orthodontics). This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read "J. Kelly", followed by a horizontal line.

President

Health Resources and Services Administration (HRSA) Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Because 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*.

Benefits for Breast Pumps

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. These Benefits are provided as described under *Preventive Care Services* in the *Certificate, Section 1: Covered Health Services* and in the *Schedule of Benefits*.

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 an acquisition.

As a result of this requirement, the exclusion for supplies, equipment and similar incidental services and supplies for personal comfort in *Section 2: Exclusions and Limitations* under *Personal Care, Comfort or Convenience* is replaced with the following:

K. Personal Care, Comfort or Convenience

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 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.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read "John Doe", written in a cursive style.

President

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling 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 Services described in the *Certificate*.

UnitedHealthcare Insurance Company



President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

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

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

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

Limitation on 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 selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

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 Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various 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 to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

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

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling *Customer Care* at 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 a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

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

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 non-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.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

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

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

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

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

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. 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 indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to Prescription Drug Products which are prescribed for an indication not approved by the *United States Food and Drug Administration* if the Prescription Drug Product has been recognized by the *Oregon Health Resources Commission* as safe and effective for treatment of a particular indication in one or more of the following sources:
 - In publications that the *Oregon Health Resources Commission* determines to be equivalent to:
 - *The American Hospital Formulary Service Drug Information*.
 - *Drug Facts and Comparisons (Lippincott-Raven Publishers)*.
 - *The United States Pharmacopoeia Dispensing Information, Volume 1*.
 - Other publications that have been identified by the *United States Secretary of Health and Human Services* as authoritative.
 - In the majority of relevant peer reviewed medical literature.
 - By the *United States Secretary of Health and Human Services*.
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 exclusion does not apply to Depo Provera and other injectable drugs used for contraception. This exclusion does not apply to immunizations administered in a Network, non-Network or a Designated Pharmacy.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the 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, and single entity vitamins.
12. Unit dose packaging 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 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. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised 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. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for smoking cessation.
19. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
21. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate. This exclusion does not apply to Benefits described under *Elemental Enteral Formula* or *Inborn Errors of Metabolism* in *Section 1: Covered Health Services* of your *Certificate of Coverage*.
22. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
23. 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 may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

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 including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

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

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Network Pharmacy - a pharmacy that has:

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

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

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

Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

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

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose monitors.

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

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, 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*.
- 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 determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

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

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

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

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict 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 determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

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

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

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

Network Pharmacy Prior Authorization

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

Non-Network Pharmacy Prior Authorization

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

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

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 a non-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 Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance 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 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 associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) and/or Pharmaceutical Product(s) first.

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

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table.

You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

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

- Copayments for Prescription Drug Products, including Specialty Prescription Drug Products.
- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

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

Payment Term And Description	Amounts
Out-of-Pocket Drug Maximum	
The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay Copayments or Coinsurance for covered Prescription Drug Products for the remainder of the year.	<p>Network and Non-Network</p> <p>\$5,000 per Covered Person, not to exceed \$10,000 for all Covered Persons in a family.</p>
Copayment and Coinsurance	
<p>Copayment</p> <p>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p>Coinsurance</p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p>Copayment and Coinsurance</p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced or increased Copayment and/or</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the 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 Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p>	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products	
<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. <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 Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, or a Designated Pharmacy.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$15 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 75% of the Prescription Drug Charge per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 70% of the Prescription Drug Charge per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Predominant Reimbursement Rate.</p> <p>Non-Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$15 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 75% of the Predominant Reimbursement Rate per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 70% of the Predominant Reimbursement Rate per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Predominant Reimbursement Rate.</p>
Prescription Drugs from a Retail 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. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or 	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$15 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>Coinsurance 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 Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>Drug Charge after you pay a Copayment of \$35 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$60 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Cost.</p>
<p>Prescription Drugs from a Retail Non-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 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <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 Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$15 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$35 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$60 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Cost.</p>
<p>Prescription Drug Products from a Mail Order 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>You may be required to fill an initial Prescription Drug Product order and obtain 1 refill through a retail pharmacy prior to</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For up to a 90-day supply, we pay:</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$37.50 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$87.50 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$150 per Prescription</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>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 Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	<p>Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Cost.</p>