# UnitedHealthcare Choice

# UnitedHealthcare of Arizona, Inc.

# Certificate of Coverage

**For**

**the Plan ESEJ**

**of**

**University of Arizona Alternative Health Care Program**

**Group Number: 730610**

**Effective Date: January 1, 2027**

# Table of Contents


**Schedule of Benefits ..... 1**
How Do You Access Benefits? ..... 1
Does Prior Authorization Apply? ..... 1
What Will You Pay for Covered Health Care Services? ..... 2
Additional Benefits Required By Arizona Law ..... 17
Allowed Amounts ..... 18
Provider Network ..... 20
Second Medical Opinion ..... 22
Designated Providers ..... 22
Health Care Services from Out-of-Network Providers ..... 22
Limitations on Selection of Providers ..... 23

**Certificate of Coverage ..... 1**
What Is the Certificate of Coverage? ..... 1
Can This Certificate Change? ..... 1
Other Information You Should Have ..... 1

**Introduction to Your Certificate ..... 2**
What Are Defined Terms? ..... 2
How Do You Use This Document? ..... 2
How Do You Contact Us? ..... 2

**Your Responsibilities ..... 3**
Eligibility, Enrollment, and Required Contributions ..... 3
Be Aware the Policy Does Not Pay for All Health Care Services ..... 3
Decide What Services You Should Receive ..... 3
Choose Your Physician ..... 3
Obtain Prior Authorization ..... 3
Pay Your Share ..... 4
Pay the Cost of Excluded Services ..... 4
Show Your ID Card ..... 4
Use Your Prior Health Care Coverage ..... 4

**Our Responsibilities ..... 5**
Determine Benefits ..... 5
Pay for Our Portion of the Cost of Covered Health Care Services ..... 5
Pay Network Providers ..... 5
Review and Determine Benefits in Accordance with our Reimbursement Policies ..... 5
Offer Health Education Services to You ..... 6

**Certificate of Coverage Table of Contents ..... 7**

**Section 1: Covered Health Care Services ..... 8**
When Are Benefits Available for Covered Health Care Services? ..... 8
1. Ambulance Services ..... 8
2. Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies ..... 9
3. Clinical Trials ..... 10
4. Congenital Heart Disease (CHD) Surgeries ..... 11
5. Dental Services - Accident Only ..... 12
6. Diabetes Services ..... 13
7. Durable Medical Equipment (DME), Orthotics and Supplies ..... 13
8. Emergency Health Care Services - Outpatient ..... 14
9. Enteral Nutrition ..... 14
10. Fertility Preservation for Iatrogenic Infertility ..... 15
11. Gender Dysphoria ..... 15

12. Habilitative Services ..... 15
13. Hearing Aids ..... 17
14. Home Health Care ..... 17
15. Hospice Care ..... 17
16. Hospital - Inpatient Stay ..... 17
17. Infertility Services ..... 18
18. Lab, X-Ray and Diagnostic - Outpatient ..... 18
19. Major Diagnostic and Imaging - Outpatient ..... 18
20. Mental Health Care and Substance-Related and Addictive Disorders Services ..... 19
21. Ostomy Supplies ..... 20
22. Pharmaceutical Products - Outpatient ..... 20
23. Physician Fees for Surgical and Medical Services ..... 20
24. Physician's Office Services - Sickness and Injury ..... 21
25. Pregnancy - Maternity Services ..... 21
26. Preimplantation Genetic Testing (PGT) and Related Services ..... 21
27. Preventive Care Services ..... 22
28. Prosthetic Devices ..... 24
29. Reconstructive Procedures ..... 24
30. Rehabilitation Services - Outpatient Therapy ..... 25
31. Scopic Procedures - Outpatient Diagnostic and Therapeutic ..... 25
32. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services ..... 26
33. Surgery - Outpatient ..... 26
34. Therapeutic Treatments - Outpatient ..... 26
35. Transplantation Services ..... 27
36. Urgent Care Center Services ..... 28
37. Urinary Catheters ..... 28
38. Virtual Care Services ..... 28
39. Vision Exams ..... 29
Additional Benefits Required By Arizona Law ..... 29
40. Biomarker Testing ..... 29
41. Manipulative Treatment ..... 30
42. Off-Label Drugs for the Treatment of Cancer ..... 30
43. Orthognathic Surgery ..... 31
44. Telehealth ..... 31

**Section 2: Exclusions and Limitations ..... 32**

How Do We Use Headings in this Section? ..... 32
We Do Not Pay Benefits for Exclusions ..... 32
Where Are Benefit Limitations Shown? ..... 32
A. Alternative Treatments ..... 32
B. Dental ..... 32
C. Devices, Appliances and Prosthetics ..... 33
D. Drugs ..... 34
E. Experimental or Investigational or Unproven Services ..... 35
F. Foot Care ..... 35
G. Medical Supplies and Equipment ..... 36
H. Nutrition ..... 36
I. Personal Care, Comfort or Convenience ..... 37
J. Physical Appearance ..... 38
K. Procedures and Treatments ..... 39
L. Providers ..... 40
M. Reproduction ..... 40
N. Services Provided under another Plan ..... 41
O. Transplants ..... 41
P. Travel ..... 41

Q. Types of Care, Supportive Services, and Housing....42
R. Vision and Hearing....42
S. All Other Exclusions....42
**Section 3: When Coverage Begins....45**
How Do You Enroll?....45
What If You Are Hospitalized When Your Coverage Begins?....45
Who Is Eligible for Coverage?....45
Eligible Person....45
Dependent....45
When Do You Enroll and When Does Coverage Begin?....45
Initial Enrollment Period....46
Open Enrollment Period....46
New Eligible Persons....46
Special Enrollment Period Required by Federal Law....46
**Section 4: When Coverage Ends....48**
General Information about When Coverage Ends....48
What Events End Your Coverage?....48
Fraud or Intentional Misrepresentation of a Material Fact....49
Coverage for a Disabled Dependent Child....49
Extended Coverage for Total Disability....49
Continuation of Coverage and Conversion....49
Conversion....50
**Section 5: How to File a Claim....51**
How Are Covered Health Care Services from Network Providers Paid?....51
How Are Covered Health Care Services from an Out-of-Network Provider Paid?....51
Payment of Benefits....51
**Section 6: Questions, Complaints and Appeals....53**
What if You Have a Question?....53
Appeals and Grievance Process....53
**Section 7: Coordination of Benefits....54**
Benefits When You Have Coverage under More than One Plan....54
When Does Coordination of Benefits Apply?....54
Definitions....54
What Are the Rules for Determining the Order of Benefit Determination Payments?....55
Effects of Benefits on this Plan....56
Right to Receive and Release Needed Information....56
Payments Made....57
Does This Plan Have the Right of Recovery?....57
**Section 8: General Legal Provisions....58**
What Is Your Relationship with Us?....58
What Is Our Relationship with Providers and Groups?....58
What Is Your Relationship with Providers and Groups?....58
Notice....59
Statements by Group or Subscriber....59
Do We Pay Incentives to Providers?....59
Are Incentives Available to You?....60
Do We Receive Rebates and Other Payments?....60
Who Interprets Benefits and Other Provisions under the Policy?....60
Who Provides Administrative Services?....60
Amendments to the Policy....60
How Do We Use Information and Records?....61
Do We Require Examination of Covered Persons?....62

Is Workers' Compensation Affected? ..... 62
When Do We Receive Refunds of Overpayments? ..... 62
Important Notice - Third Party Payers ..... 62
Is There a Limitation of Action? ..... 62
What Is the Entire Policy? ..... 62
**Section 9: Defined Terms ..... 63**
**Section 10: Consolidated Appropriations Act Summary ..... 77**
No Surprises Act ..... 77
Balance Billing ..... 77
Determination of Our Payment to the Out-of-Network Provider: ..... 77
Continuity of Care ..... 77
Provider Directories ..... 79

# Amendments, Riders and Notices (As Applicable)

**Outpatient Prescription Drug Rider**
**Doula Support Program Rider**
**Real Appeal Rider**
**UnitedHealthcare Rewards Rider**
**Language Assistance Services**
**Notice of Non-Discrimination**
**Important Notices**
**Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights**
**ERISA Statement**

# UnitedHealthcare Choice

# UnitedHealthcare of Arizona, Inc.

# Schedule of Benefits

## How Do You Access Benefits?

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits,* Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits. You may designate a Network pediatrician for an Enrolled Dependent child. For obstetrical or gynecological care, you may seek care directly from any Network obstetrician or gynecologist.

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

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

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

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

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

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

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

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

## Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for

services they do not prior authorize as required. If prior authorization is required for a certain Covered Health Care Services, providers must use the uniform prior authorization request form approved by the Arizona *Department of Insurance* on or after January 1, 2023 or the request will be invalid. You can call us at the telephone number on your ID card.

## What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a calendar year basis.

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

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

| **Payment Term And Description** | **Amounts** |
|---|---|
| **Annual Deductible** | |
| The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits.<br><br>Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.<br><br>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.<br><br>The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. | Designated Network and Network<br><br>$200 per Covered Person, not to exceed $400 for all Covered Persons in a family. |
| **Out-of-Pocket Limit** | |
| The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider*.<br><br>Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.<br><br>The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still | Designated Network and Network<br><br>$7,350 per Covered Person, not to exceed $14,700 for all Covered Persons in a family.<br><br>The Out-of-Pocket Limit includes the Annual Deductible. |

| Payment Term And Description | Amounts |
|---|---|
| will be required to pay the following:<br>• Any charges for non-Covered Health Care Services.<br>• Charges that exceed Allowed Amounts, when applicable.<br>• Co-payments or Co-insurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. | |
| **Co-payment** | |
| Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.<br>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:<br>• The applicable Co-payment.<br>• The Allowed Amount or the Recognized Amount when applicable.<br>Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. | |
| **Co-insurance** | |
| Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.<br>Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. | |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| **1. Ambulance Services** | | | |
| In most cases, we will initiate and direct non-Emergency ambulance transportation. | | | |
| **Emergency Ambulance**<br>Ground, water or Air Ambulance.<br>Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*. | *Ground Ambulance*<br>None<br>*Air Ambulance*<br>None<br>*Water Ambulance*<br>None | <br>Yes<br><br>Yes<br><br>Yes | <br>Yes<br><br>Yes<br><br>Yes |
| **Non-Emergency Ambulance**<br>Ground, water or Air Ambulance.<br>Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*. | *Ground Ambulance*<br>None<br>*Air Ambulance*<br>None<br>*Water Ambulance*<br>None | <br>Yes<br><br>Yes<br><br>Yes | <br>Yes<br><br>Yes<br><br>Yes |
| **2. Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies** | | | |
| Cellular Therapy, Gene Therapy, or other genetic/molecular therapy services must be received from a | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics –* | | |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| Designated Provider.<br>Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services and preservice management will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. | *Outpatient; Physician Fees for Surgical and Medical Services;* and *Physician Office Services – Sickness and Injury* in this *Schedule of Benefits.* | | |
| **3. Clinical Trials** | | | |
| Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services;* and *Physician Office Services – Sickness and Injury* in this *Schedule of Benefits.* | | |
| **4. Congenital Heart Disease (CHD) Surgeries** | | | |
| **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.** | | | |
| Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. | $250 per Inpatient Stay | Yes | Yes |
| **5. Dental Services - Accident Only** | | | |
| | None | Yes | Yes |
| **6. Diabetes Services** | | | |
| **Diabetes Self-Management and** | Depending upon where the Covered Health Care Service is | | |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| **Training/Diabetic Eye Exams/Foot Care**<br><br>**Diabetes Self-Management Items**<br>Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.* | provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under *Physician Office Services – Sickness and Injury* in this *Schedule of Benefits*.<br><br>Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*. | | |
| **7. Durable Medical Equipment (DME), Orthotics and Supplies** | | | |
| Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years.<br><br>You must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician. | None | Yes | Yes |
| **8. Emergency Health Care Services - Outpatient** | | | |
| **Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network | $200 per visit. | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided.<br><br>If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.<br><br>Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*. | | | |
| **9. Enteral Nutrition** | | | |
| | None | Yes | Yes |
| **10. Fertility Preservation for Iatrogenic Infertility** | | | |
| Limited to $25,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under *Preimplantation Genetic Testing (PGT) and Related Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. | None | Yes | Yes |
| **11. Gender Dysphoria** | | | |
| **It is important that you notify us as soon as the possibility of surgery arises. Your notification** | | | |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| **allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.** | | | |
| | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices;* and/or *Reconstructive Procedures* in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*. | | |
| **12. Habilitative Services** | | | |
| Inpatient services limited per year as follows:<br>Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*. | *Inpatient*<br>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services* in this *Schedule of Benefits.* | | |
| Outpatient therapies:<br>• Physical therapy.<br>• Occupational therapy.<br>• Speech therapy.<br>• Post-cochlear implant aural therapy.<br>• Cognitive therapy.<br>For the above outpatient therapies:<br>Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy*.<br>Limits above do not apply to the | *Outpatient*<br>$20 per visit | Yes | Yes |

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|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| treatment of Mental Illness or substance-related and addictive disorders. | | | |
| **13. Hearing Aids** | | | |
| Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. | None | Yes | Yes |
| **14. Home Health Care** | | | |
| Limited to 60 visits per year. One visit equals up to four hours of skilled care services.<br>This visit limit does not include any service which is billed only for the administration of intravenous infusion.<br>For the administration of intravenous infusion, you must receive services from a provider we identify as a Designated Provider. | None | Yes | Yes |
| **15. Hospice Care** | | | |
| | None | Yes | Yes |
| **16. Hospital - Inpatient Stay** | | | |
| | $250 per Inpatient Stay | Yes | Yes |
| **17. Infertility Services** | | | |
| Limited to $25,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and for related services as | None | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| described under *Preimplantation Genetic Testing (PGT) and Related Services*. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below. | | | |
| **18. Lab, X-Ray and Diagnostic - Outpatient** | | | |
| **Lab Testing - Outpatient**<br><br>**X-Ray and Other Diagnostic Testing - Outpatient** | None<br><br>None | Yes<br><br>Yes | Yes<br><br>Yes |
| **19. Major Diagnostic and Imaging - Outpatient** | | | |
| | $100 per service<br>None, for the first breast MRI in a year;<br>$100 per service for any subsequent breast MRI in that year | Yes<br>Yes<br>Yes | Yes<br>Yes<br>Yes |
| **20. Mental Health Care and Substance-Related and Addictive Disorders Services** | | | |
| | *Inpatient*<br>$250 per Inpatient Stay<br>*Outpatient*<br>***Outpatient Office*** | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| | ***Visit***<br>$20 per visit | Yes | Yes |
| | ***Outpatient Other***<br>*Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* | | |
| | None | Yes | Yes |
| | *Intensive Behavioral Therapy* | | |
| | None | Yes | No |
| | *All Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and Medication Assisted Treatment* | | |
| | None | Yes | No |
| **21. Ostomy Supplies** | | | |
| | None | Yes | Yes |
| **22. Pharmaceutical Products - Outpatient** | | | |
| | None | Yes | Yes |
| **23. Physician Fees for Surgical and Medical Services** | | | |
| Allowed Amounts for Covered Health Care Services provided by an out-of-Network Physician in certain Network | None | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*. | | | |
| **24. Physician's Office Services - Sickness and Injury** | | | |
| Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office:<br>• Major diagnostic and nuclear medicine described under Major *Diagnostic and Imaging - Outpatient*.<br>• Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*.<br>• Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.<br>• Outpatient surgery procedures described under *Surgery - Outpatient*.<br>• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.<br>**Note:** When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing whether performed in or out of the Physician's office will apply additional cost | **For Covered Persons under the age of 19:**<br>None per visit for a Primary Care Physician office visit or $40 per visit for a Specialist office visit | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| sharing as described above.<br><br>Additional cost sharing (Co-payments/Co-insurance and any deductible), will not apply to the following Covered Health Care Services from a Primary Care Physician as described in the *Certificate of Coverage* when performed in a Physician's office:<br><br>• Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*.<br><br>• Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.<br><br>• Outpatient surgery procedures described under *Surgery - Outpatient.*<br><br>**Note:** When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing performed outside of the Physician's office is not included in the exception of additional cost-sharing described above. | **For Covered Persons age 19 and older:**<br><br>$20 per visit for a Primary Care Physician office visit or $40 per visit for a Specialist office visit | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| **25. Pregnancy - Maternity Services** | | | |
| The coverage for birth costs for an adopted child under this Policy is secondary to any coverage for maternity-related expenses that the birth mother may have and Benefits will be coordinated as described in the *Certificate Section 7: Coordination of Benefits*. | Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services;* and *Physician Office Services – Sickness and Injury* in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. | | |
| **26. Preimplantation Genetic Testing (PGT) and Related Services** | | | |
| Benefit limits for related services will be the same as, and combined with, those stated under *Infertility Services*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. | None | Yes | Yes |
| **27. Preventive Care Services** | | | |
| **Physician office services** | None | No | No |
| **Lab, X-ray or other preventive tests** | None | No | No |
| **Breast pumps** | None | No | No |
| **28. Prosthetic Devices** | | | |
| Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.<br><br>Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*. Benefits must be available for at least two external post-operative breast | None | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| prostheses. | | | |
| **29. Reconstructive Procedures** | | | |
| | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury* and *Prosthetic Devices* in this *Schedule of Benefits*. | | |
| **30. Rehabilitation Services - Outpatient Therapy** | | | |
| Limited per year as follows:<br>• 30 visits of physical therapy.<br>• 30 visits of occupational therapy.<br>• 30 visits of speech therapy.<br>• 30 visits of pulmonary rehabilitation therapy.<br>• 36 visits of cardiac rehabilitation therapy.<br>• 30 visits of post-cochlear implant aural therapy.<br>• 30 visits of cognitive rehabilitation therapy.<br>Limits above do not apply to the treatment of Mental Illness or substance-related and addictive disorders. | $20 per visit | Yes | Yes |
| **31. Scopic Procedures - Outpatient Diagnostic and Therapeutic** | | | |
| | None | Yes | Yes |
| **32. Skilled Nursing Facility/Inpatient Rehabilitation** | | | |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| **Facility Services** | | | |
| Limited to 60 days per year. | $250 per Inpatient Stay | Yes | Yes |
| **33. Surgery - Outpatient** | | | |
| | $50 per date of service | Yes | Yes |
| **34. Therapeutic Treatments - Outpatient** | | | |
| | None | Yes | Yes |
| **35. Transplantation Services** | | | |
| Transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider. | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury* and *Surgery - Outpatient* in this *Schedule of Benefits.* | | |
| **36. Urgent Care Center Services** | | | |
| Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center:<br>• Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*.<br>• Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*.<br>• Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and* | $75 per visit | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| *Therapeutic*.<br>• Outpatient surgery procedures described under *Surgery - Outpatient*.<br>• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. | | | |
| **37. Urinary Catheters** | | | |
| | None | Yes | Yes |
| **38. Virtual Care Services** | | | |
| Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card. | None | Yes | No |
| **39. Vision Exams** | | | |
| Limited to 1 exam every 2 years. | $20 per visit | Yes | Yes |
| **Additional Benefits Required By Arizona Law** | | | |
| **40. Biomarker Testing** | | | |
| | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services*; and *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits*. | | |
| **41. Manipulative Treatment and Chiropractic Care** | | | |
| | $40 per visit | Yes | Yes |

| **Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.** | | | |
|---|---|---|---|
| **Covered Health Care Service** | **What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.** | **Does the Amount You Pay Apply to the Out-of-Pocket Limit?** | **Does the Annual Deductible Apply?** |
| **42. Off-Label Drugs for the Treatment of Cancer** | | | |
| | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Pharmaceutical Products - Outpatient* and *Physician Office Services – Sickness and Injury* in this *Schedule of Benefits* or as described under *the Outpatient Prescription Drug Schedule of Benefits*. | | |
| **43. Orthognathic Surgery** | | | |
| | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury; Surgery - Outpatient;* and *Temporomandibular Joint (TMJ) Services* in this *Schedule of Benefits*. | | |
| **44. Telehealth** | | | |
| | Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Lab, X-Ray and Diagnostics – Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient;* and *Physician Office Services – Sickness and Injury* in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug Schedule of Benefits.* | | |

## Allowed Amounts

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

- For Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians****,* you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate*.

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

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

**Benefits,** Allowed Amounts are based on the following:

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

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

**For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

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

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

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

- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

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

**For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

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

**For Emergency ground ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is a rate approved by the *Arizona Department of Health Services.*

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

## Provider Network

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

We have an effective process for continuing review and evaluation of the Covered Health Care Services that we provide to you to ensure treatment and level of Covered Health Care Services are appropriate and adequate. Our credentialing process confirms public information about the providers' licenses and other credentials, assures the quality of the services provided are acceptable. We have a quality assurance committee that arranges for Physicians or practitioners to review and evaluate Covered Health Care Services provided by other Physicians or practitioners within their respective disciplines and adopts administrative procedures covering frequency of meetings, recordkeeping, committee reports, and disseminating the reports. Our process includes the following:

- Standards for Covered Health Care Services.
- Monitoring of care.
- Analysis of any deficiency.
- Correcting a deficiency, including submitting a schedule for correcting the deficiency, requiring continued education for the provider, if appropriate, and follow-up and periodic reassessment of the deficiency.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your

request for such information (via telephone, electronic, web-based or internet-based means), you will be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider if it is determined that we incorrectly informed you that the provider was a Network provider.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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

***Continuity of Care***

If you are a new enrollee whose current health care provider is not a Network provider, you may request, in writing, to continue an active course of treatment with that out-of-Network provider during a transitional period after the effective date of enrollment if both of the following apply:

- You have either:
  - A life-threatening disease or condition, in which case the transitional period is not more than 30 days after the effective date of the enrollment; or
  - Entered the third trimester of Pregnancy on the effective date of the enrollment, in which case the transitional period include the delivery and care related to the delivery up to six weeks after the delivery.
- Your health care provider agrees in writing to do all of the following:
  - Accept as payment in full our Network rates that apply to similar services provided by Network providers (except for applicable Co-payment or Annual Deductible amounts).
  - Comply with our quality assurance requirements and provide us with any necessary medical information related to the care.
  - Comply with our policies and procedures including procedures relating to referrals, prior notification and claims handling.

If your health care provider is terminated by us from the provider Network (except for reasons of medical incompetence or unprofessional conduct), you may request, in writing, to continue an active course of treatment with that health care provider during a transitional period after the date the provider is no longer in the Network if both of the following apply:

- You have either:
  - A life-threatening disease or condition, in which case the transitional period is not more than 30 days after the date the provider is no longer in the Network; or

- Entered the third trimester of Pregnancy on the date the provider is no longer in the Network, in which case the transitional period includes the delivery and any care related to the delivery up to six weeks after the delivery.

- Your health care provider agrees in writing to do all of the following:
  - Continue to accept as payment in full our Network rates that were applicable before the beginning of the transitional period (except for applicable Co-payment or Annual Deductible amounts).
  - Comply with our quality assurance requirements and provide us with any necessary medical information related to the care.
  - Comply with our policies and procedures including procedures relating to referrals, prior notification and claims handling.

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

## Second Medical Opinion

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Physician or appropriately qualified health care professional. In most cases, you or your treating Physician or health care professional will request a second medical opinion without consulting us. A second medical opinion is covered under the *Physician's Office Services - Sickness and Injury* Benefit.

Please Note: The fact that an appropriately qualified Physician or health care professional gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended health care service is Medically Necessary or a Covered Health Care Service under the Policy. The health care service, supply or Pharmaceutical Product is only a Covered Health Care Service if it is Medically Necessary and a Covered Health Care Service under the Policy. Please see *Section 1: Covered Health Care Services* in the *Certificate of Coverage* for the Benefits available under the Policy.

## Designated Providers

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

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

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

## Health Care Services from Out-of-Network Providers

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

Emergency or if we refer you to an out-of-Network provider, we will reimburse you for any out-of-Network cost you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider. A Network exception does not include Benefits if you decide to go out-of-Network for Covered Health Care Services. Network exceptions must be arranged by us.

## Limitations on Selection of Providers

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

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

If you do not use the selected Network Physician, Benefits will not be paid.

# Certificate of Coverage

# UnitedHealthcare of Arizona, Inc.

## What Is the Certificate of Coverage?

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

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

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

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

## Can This Certificate Change?

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

## Other Information You Should Have

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

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

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

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

# Introduction to Your Certificate

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

## What Are Defined Terms?

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

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

## How Do You Use This Document?

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

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

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

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

## How Do You Contact Us?

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

# Your Responsibilities

## Eligibility, Enrollment, and Required Contributions

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

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

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

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

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

## Decide What Services You Should Receive

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

## Choose Your Physician

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

## Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization.

A prior authorization request, once granted or deemed granted, is binding on us, may be relied on by you and the Physician and may not be rescinded or modified by us or our utilization review agent after the Physician renders the authorized health care services in good faith and pursuant to the authorization unless there is evidence of fraud or misrepresentation by the provider.

For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

## Pay Your Share

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

If you receive a Covered Health Care Service from an out-of-Network provider as a result of an Emergency, we will reimburse the out-of-Network provider for any out-of-Network cost you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider. You should not pay the out-of-Network provider directly for Emergency Health Care Services with the exception of any Co-payment and/or Co-insurance you are responsible for paying under the Policy. However, if you receive Covered Health Care Services from an out-of-Network provider for Emergency Health Care Services and you paid the out-of-Network provider directly, we will reimburse you for the Allowed Amount. If you receive a bill for Emergency Health Care Services from an out-of-Network provider, please refer to *Section 5: How to File a Claim*.

## Pay the Cost of Excluded Services

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

## Show Your ID Card

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

## 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, Benefits for that particular condition or disability are subject to your previous carrier's obligation under state law or contract.

# Our Responsibilities

## Determine Benefits

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

We have the final authority to do the following:

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

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

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

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

## Pay Network Providers

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

## Review and Determine Benefits in Accordance with our Reimbursement Policies

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

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As indicated in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by *the American Psychiatric Association* for the diagnosis and treatment of Mental Illnesses and alcoholism and substance-related and addictive disorders.
- 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. If you receive a Covered Health Care Service from an out-

of-Network provider as a result of an Emergency or if we authorize services from an out-of-Network provider, we will reimburse the out-of-Network provider for any out-of-Network cost you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

## Offer Health Education Services to You

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

# Certificate of Coverage Table of Contents

**Section 1: Covered Health Care Services .....8**
**Section 2: Exclusions and Limitations.....32**
**Section 3: When Coverage Begins .....45**
**Section 4: When Coverage Ends .....48**
**Section 5: How to File a Claim .....51**
**Section 6: Questions, Complaints and Appeals.....53**
**Section 7: Coordination of Benefits .....54**
**Section 8: General Legal Provisions .....58**
**Section 9: Defined Terms .....63**
**Section 10: Consolidated Appropriations Act Summary.....77**

# Section 1: Covered Health Care Services

## When Are Benefits Available for Covered Health Care Services?

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

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

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

Benefits are provided for nutritional counseling services provided by an appropriate licensed or registered health care professional for the treatment of medical or mental health conditions. Benefits for the services are provided under the applicable Benefit category in this section. Nutritional counseling services for preventive care are described under *Preventive Care Services*.

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

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

***Please note that 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."***

**Outpatient Facility Charges:** Benefits are available for the facility charge and related charge for supplies and equipment for Covered Health Care Services. Depending upon where the Covered Health Care Service is provided, Benefits for outpatient facility charges will be the same as those stated under each Covered Health Care Service category in the *Schedule of Benefits*.

### 1. Ambulance Services

Emergency ambulance services, without prior authorization, to the nearest Hospital or other facility that is licensed or otherwise authorized to furnish Emergency Health Care Services.

Non-Emergency ambulance services between facilities only when the transport meets one of the following:

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

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

- "Ambulance" means any publicly or privately owned surface, water or air vehicle, including a helicopter, that contains a stretcher and necessary medical equipment and supplies pursuant to *Arizona Revised Statutes Section 36-2202* and that is especially designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded or who require medical monitoring or aid. Ambulance does not include a surface vehicle that is owned and operated by a private sole proprietor, partnership, private corporation or municipal corporation for the emergency transportation and in-transit care of its employees or a vehicle that is operated to accommodate an incapacitated person or person with a disability who does not require medical monitoring, care or treatment during transport and that is not advertised as having medical equipment and supplies or ambulance attendants.
- "Emergency ambulance services" means services provided by an Ambulance service authorized to operate pursuant to *Arizona Revised Statutes Title 36, Chapter 21.*1 following the onset of a medical condition that manifests itself by symptoms of pain, illness, or Injury that the absence of accessing an ambulance or emergency response by calling 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:
  - Placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.
- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

## 2. Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies

Cellular Therapy, Gene Therapy, and other genetic/molecular therapies received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility, a Physician's office, or in your home, including biomarker testing. These therapies must be provided by a Designated Provider.

Please refer to *Pharmaceutical Products - Outpatient* in this *Certificate* for Cellular Therapy, Gene Therapy, and other genetic/molecular therapies that do not need to be provided by a Designated Provider.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for Cellular Therapy, Gene Therapy, and other genetic/molecular therapies.

## 3. Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
    - *Category B* devices are determined by the *FDA*, non-experimental and/or investigational devices where the incremental risk is the primary risk in question (i.e. underlying questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained *FDA* approval for that device.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.

- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- With respect to a clinical trial for the treatment of cancer, the personnel providing the treatment or conducting the study are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training, and volume of patients treated to maintain expertise.

## 4. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

## 5. Dental Services - Accident Only

Dental services when all of the following are true:

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

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

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

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

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

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.

- Replacement of lost teeth due to Injury with implant, dentures or bridges.

## 6. Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits for diabetes self-management training include training, after the initial diagnosis, in the care and management of diabetes, including proper use of diabetes equipment and supplies.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes, and to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes.

Benefits are available for therapeutic shoes for diabetes mellitus and any of the following complications involving the foot: peripheral neuropathy with evidence of callus formation; or history or pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

**Diabetic Self-Management Items**

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for diabetic supplies are described under the *Outpatient Prescription Drug Rider* and include the following:

- Blood glucose monitors.
- Blood glucose monitors for the legally blind.
- Test strips for glucose monitors and visual reading and urine testing strips.
- Insulin preparations and glucagon.
- Insulin cartridges.
- Drawing up devices and monitors for the visually impaired.
- Injection aids.
- Insulin cartridges for the legally blind.
- Syringes and lancets, including automatic lancing devices.
- Prescribed oral agents for controlling blood sugar.
- Any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999.

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

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

*DME and Supplies*

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.

- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

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

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

*Orthotics*

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

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

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

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

## 8. Emergency Health Care Services - Outpatient

A screening exam and services that are required to stabilize or begin treatment in an Emergency including the assessment and stabilization of a psychiatric Emergency medical condition. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency Health Care Services do not require prior authorization.

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

## 9. Enteral Nutrition

Benefits are provided for enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician. You must have one of the following conditions to receive Benefits for enteral nutrition:

- Inborn Errors of Metabolism (such as phenylketonuria (PKU), maple syrup urine disease, homocystinuria, methylmalonic acidemia, propionic acidemia, isovaleric acidemia, and other disorders of leucine metabolism; glutaric aciduria type I and tyrosinemia types I and II; and urea cycle disorders).

- Chronic kidney disease (CKD) stages 2 to 5 (or on dialysis) for individuals ages less than 24 months.
- Crohn's disease.
- Severe malabsorption syndrome (such as cystic fibrosis, short bowel syndrome, or intestinal failure).
- Malnutrition or individual will become malnourished or suffer from severe disorders such as physical disability, intellectual disability or death if the nutritional therapy is not instituted. For purposes of this Benefit, "intellectual disability" is a neurodevelopmental disorder that is characterized by deficits in both intellectual functioning and adaptive functioning, whose onset is in the developmental period.
- Severe food allergies, including eosinophilic esophagitis and other forms of eosinophilic gastrointestinal diseases, which, if left untreated, will cause life-threatening allergic reactions, malnourishment, or death.
- Gastroesophageal reflux with failure to thrive.

## 10. Fertility Preservation for Iatrogenic Infertility

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

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

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

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

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

## 11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician. Benefits include hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.

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

## 12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the

purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

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

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

The following are not habilitative services:

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

We may require the following be provided:

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

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

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

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

## 13. Hearing Aids

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

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

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

Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the *Surgery - Outpatient, Physician Fees for Surgical and Medical Services* and *Durable Medical Equipment (DME), Orthotics and Supplies* Covered Health Care Services categories in this *Certificate*. They are only available if you have either of the following:

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

## 14. Home Health Care

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

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

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

## 15. Hospice Care

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

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

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

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

## 16. Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Private hospital rooms and/or Private Duty Nursing when determined to be Medically Necessary by us.

## 17. Infertility Services

Services for the treatment of infertility, not related to voluntary sterilization or failed reversal of voluntary sterilization, when provided by or under the care or supervision of a Physician, limited to the following:

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

## 18. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography. Services include digital breast tomosynthesis, ultrasound or other modality and at such age and intervals as recommended by the *National Comprehensive Cancer Network*. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously or dense breast tissue based on the breast imaging reporting and data system of the *American College of Radiology*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- With respect to men, screening for prostate cancer for all men age 40 and older.
- Presumptive Drug Tests and Definitive Drug Tests.

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

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

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

## 19. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

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

## 20. Mental Health Care and Substance-Related and Addictive Disorders Services

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

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office.

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures, including Electroconvulsive therapy (ECT) and neuropsychological testing.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Psychiatric services.
- Detoxification.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are both of the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.

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

## 21. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

## 22. Pharmaceutical Products - Outpatient

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

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

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

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product(s) for which Benefits are provided as described under the *Outpatient Prescription Drug Rider* first.

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

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

For Cellular Therapy, Gene Therapy, and other genetic/molecular therapies that are provided by a Designated Provider, please refer to *Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies* as described in this *Certificate*.

## 23. Physician Fees for Surgical and Medical Services

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

## 24. Physician's Office Services - Sickness and Injury

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

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals.

Benefits include nutritional evaluation and counseling provided by a Physician when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including: morbid obesity, diabetes, cardiovascular disease, hypertension, kidney disease, eating disorders, gastrointestinal disorders, food allergies and hyperlipidemia.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections and antigen administration. Benefits for allergy testing are provided under *Lab, X-Ray and Diagnostics - Outpatient*.

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

## 25. Pregnancy - Maternity Services

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

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

We will pay Benefits for an Inpatient Stay or birthing center 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.

Benefits are available for maternity-related medical, Hospital and other Covered Health Care Services for the birth of any child legally adopted by the Subscriber if all of the following are true:

- The child is adopted within one year of birth.
- The Subscriber is legally obligated to pay the costs of birth.
- The Subscriber has notified us of his or her acceptability to adopt children within 60 days after approval is received or within 60 days after a change in health care coverage.

This coverage is secondary to any coverage for maternity-related expenses that the birth mother may have and Benefits will be coordinated as described in *Section 7: Coordination of Benefits*.

## 26. Preimplantation Genetic Testing (PGT) and Related Services

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

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).

- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryo-preservation and short-term embryo storage (less than one year).

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

## 27. 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 counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions, and prevention of human immunodeficiency virus (HIV) infection. You may view the list of "A" and "B" recommendations at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.* You may view the vaccine recommendations and guidelines at: **https://www.cdc.gov/vaccines/schedules/index.html**.
- 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*. Benefits include:
    - Screening newborns for hearing problems, thyroid disease, phenylketonuria, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases.
    - For children: counseling for fluoride for prevention of dental cavities; screening for major depressive disorders; vision; lead; tuberculosis; developmental disorders/Autism Spectrum Disorders; counseling for obesity.
    - Well child visits and immunizations covered through 47 months as recommended by the *American Academy of Pediatrics*.

    You may view the recommendations for preventive pediatric health care at: **https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**.

    You may view the *Bright Futures* well-child visits parent and patient education handouts at: **https://www.aap.org/en/practice-management/bright-futures/bright-futures-family-centered-care/well-child-visits-parent-and-patient-education/**.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits include:
    - Preventive care visits to include preconception and prenatal services.

- Breastfeeding support and counseling, includes lactation support counseling during pregnancy and/or in the post-partum period.
- Human papillomavirus (HPV) DNA testing for women 30 years and older.
- Domestic violence screening and counseling.
- Annual human immunodeficiency virus (HIV) screening and counseling.
- Annual sexually-transmitted infection counseling.
- Screening for gestational diabetes for all pregnant women that have no prior history of diabetes.
- Genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing.
- Osteoporosis screening.

You may view the recommendations for well-woman care at: **https://www.womenspreventivehealth.org/wellwomanchart/**.

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

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

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

- Benefits for screening mammography include digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality and at such age and intervals as recommended by the *National Comprehensive Cancer Network*. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously or dense breast tissue based on the breast imaging reporting and data system of the *American College of Radiology*. Benefits for diagnostic imaging are provided as described under *Lab, X-Ray and Diagnostic - Outpatient and Major Diagnostic and Imaging - Outpatient*.
- With respect to all at an appropriate age and/or risk status, Benefits include:
  - Counseling and/or screening for: colorectal cancer, elevated cholesterol and lipids; sexually transmitted diseases; human immunodeficiency virus (HIV); depression; high blood pressure; diabetes; Preventive Care Medications.
  - Screening and counseling for alcohol abuse in a primary care setting; obesity; diet and nutrition.
  - Behavioral counseling to prevent skin cancer for ages 10 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Benefits for Preventive Care Medications are provided as described under the *Outpatient Prescription Drug Rider*.

  An exception process may apply to certain categories of preventive care services if your health care provider determines that an alternative preventive care service is Medically Necessary for you.

An expedited exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health.

To request an exception your health care provider must fill out the exception request form with the appropriate clinical information and attest that the requested preventive care service is Medically Necessary for you.

If a request for an exception is approved by us, Benefits provided for the health care service will be treated the same as a preventive care service Benefit.

For more information and to access the exception request form, please visit www.uhcprovider.com then go to *Resource Library and Provider Forms (Commercial Plans)*. For questions, call the telephone number shown on your ID Card.

## 28. Prosthetic Devices

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

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

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics, including osseointegrated limbs, are a Covered Health Care Service for which Benefits are available under the *Hospital - Inpatient Stay* and *Surgery - Outpatient* Covered Health Care Service categories in this *Certificate.*

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

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

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

## 29. Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance except for reconstructive procedures following a mastectomy as required by the *Women's Health and Cancer Rights Act of 1998*.

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

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 (at least two external post-operative breast prostheses) and treatment of complications (including lymphedemas), are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

## 30. 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 include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

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

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

Benefits are not available for maintenance/preventive treatment.

## 31. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

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

## 32. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

## 33. Surgery - Outpatient

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

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

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

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

Benefits include:

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

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

## 34. Therapeutic Treatments - Outpatient

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

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

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals.

Benefits include:

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

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

## 35. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service. Transplant related services include evaluation, candidacy, transplant event, or post-transplant care. Covered Health Care Services also include the costs for the organ procurement.

Examples of transplants for which Benefits are available include:

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

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

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

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

**Benefits for Transplantation Travel Services:**

Travel expenses incurred by you in connection with a prior authorized organ and/or tissue transplant are covered subject to the following conditions and limitations:

- Travel expenses are limited to $10,000.
- Benefits for organ transplant travel expenses are not available for cornea transplants.
- Benefits for transportation, lodging and food are available only for you if you are receiving a prior-authorized organ and/or tissue transplant or transplant related services from a Network transplant facility designated by us.

All claims filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated based on your home address and the transplant facility location. Travel expenses will include charges for:

- Transportation to and from the transplant facility location (including charges for a rental car used during a period of care at the transplant facility.
- Transportation to and from the transplant site in a personal vehicle which will be reimbursed per mile (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel) when the transplant facility location is more than 60 miles one way from your home.
- Lodging while at, or traveling to and from the transplant facility location.
- Food while at, or traveling to and from the transplant facility location.

In addition to the covered travel expenses listed above, Benefits for travel expenses are also available for one companion to accompany you while you are receiving the transplantation services. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. Expenses incurred by your companion will be accumulated toward your $10,000 limit per transplantation service described above.

## 36. Urgent Care Center Services

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

## 37. Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

## 38. Virtual Care Services

Virtual care services are distinct from telehealth services since there no restrictions on where virtual visit services can originate. Virtual care services cover audio visual visits by our Designated Virtual Network Providers and are accessible from any location. Telehealth services has the ability for local Network providers to offer either in-person or telehealth visits with their paneled patients for the market(s) they are licensed to perform clinical services in.

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

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

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

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

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

## 39. Vision Exams

Routine vision exams received from a health care provider in the provider's office or outpatient facility. Routine vision exams include refraction to find vision impairment.

Benefits for eye exams 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 Arizona Law

## 40. Biomarker Testing

Benefits for biomarker testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition when the test provides clinical utility as demonstrated by medical and scientific evidence, including any of the following:

- Labeled indications for tests that are approved or cleared by the *United States Food and Drug Administration* or indicated tests for a drug that is approved by the *United States Food and Drug Administration*.
- *Centers for Medicare and Medicaid Services* national coverage determinations or Medicare administrative contractor local coverage determinations.
- Nationally recognized clinical practice guidelines and consensus statements.

For the purpose of this Benefit:

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention. Biomarker includes gene mutations or protein expression.

"Biomarker testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker. Biomarker testing includes single-analyte tests, multiplex panel tests and whole genome sequencing.

"Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

"Consensus statements" means statements that both:

- are developed by an independent, multidisciplinary panel of experts using a transparent methodology and reporting structure that includes a conflict of interest policy.

- Are based on the best available evidence for the purpose of optimizing clinical care outcomes.
- Are aimed at specific clinical circumstances.

"Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that both:

- Are developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and a conflict of interest policy.
- Establish standards of care that are informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options that includes recommendations intended to optimize patient care.

## 41. Manipulative Treatment

Benefits for Manipulative Treatment must be performed by a Network chiropractic provider for a minimum of 12 self-referred visits per year. Please refer to the *Schedule of Benefits* to determine the exact number of covered visits per year your Benefit plan offers.

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

- You are not progressing in goal-directed Manipulative Treatment.
- Treatment goals have previously been met.

Benefits are not available for maintenance/preventive Manipulative Treatment.

## 42. Off-Label Drugs for the Treatment of Cancer

Benefits are available for drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:

- The acceptable standard medical reference compendia are the following:
  - The *American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.
  - The *National Comprehensive Cancer Network Drugs and Biologics Compendium*.
  - *Thomson Micromedex Compendium DRUGDEX*.
  - *Elsevier Gold Standard's Clinical Pharmacology Compendium*.
  - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
- Medical literature may be accepted if all of the following apply:
  - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
  - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
  - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human*

*Services* as acceptable peer-reviewed medical literature, pursuant to *Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B)*.

## 43. Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are provided when determined to be Medically Necessary.

## 44. Telehealth

Benefits are available for health care services received through telehealth if the health care service would be covered were it provided through in-person encounter between you and a health care provider and provided to you while receiving the Covered Health Care Service in the state of Arizona. Benefits are also provided for Remote Physiological Monitoring. We will not limit or deny Covered Health Care Services provided through telehealth and may apply only the same limits or exclusions on health care services provided through telehealth, including ancillary services, that are applicable to an in-person encounter for the same health care service, except for procedures or services as identified by the diagnostic and procedures codes, for which the weight of evidence, based on practice guidelines, peer-reviewed clinical publications or research or recommendations by the *Telehealth Advisory Committee on Telehealth Best Practices*, determines not to be appropriate to be provided through telehealth. Health care services appropriately provided through telehealth are subject to all terms and conditions of the Policy.

Health care services provided through telehealth or resulting from a telehealth encounter are subject to all of Arizona state laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona license requirements, and any practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

For the purpose of this Benefit:

"Telehealth" means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the purpose of diagnosis, encounter or treatment. Telehealth includes:

- The use of an audio-only telephone encounter between you and your Physician or Network provider if both of the following apply:

  An audio-visual telehealth encounter is not reasonably available due to your functional status, lack of technology or telecommunications infrastructure limits, as determined by your Physician or other Network provider.

  The telehealth encounter is initiated at your request or authorized by you before the telehealth encounter.

- The use of an audio-only encounter between you and your Physician or other Network provider, regardless of whether there is an existing relationship with the Physician or other health care provider, if the telehealth encounter is for a Covered Health Care Service for Mental Health Care Services or Substance-Related and Addictive Disorders Services and both items (1) and (2) apply.

Telehealth does not include the sole use of a FAX machine, instant messages, voice mail or email.

# Section 2: Exclusions and Limitations

## How Do We Use Headings in this Section?

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

## We Do Not Pay Benefits for Exclusions

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

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

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

## Where Are Benefit Limitations Shown?

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

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

## A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing, and
6. Other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. Alternative treatments are those developed outside of mainstream western, or conventional, medicine and used in place of conventional medicine. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

## B. Dental

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

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

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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

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

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

## C. Devices, Appliances and Prosthetics

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

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.

- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Over-the-counter continuous glucose monitors.

## D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to:
   - Aspirin for which Benefits are available as recommended by the *United States Preventive Task Force* as a preventive care service.
   - Counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
   - All other *United States Preventive Services Task Force* "A" and "B" recommended over-the-counter medications and supplements when prescribed by a Network provider. You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at **http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations**.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

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

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives to another Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider* available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

## E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

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

## F. Foot Care

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

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes. This exclusion does not apply to podiatric appliances or therapeutic footwear for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

5. Shoe orthotics. This exclusion does not apply to orthotics for which Benefits are provided as described under *Diabetes Services* or *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

6. Shoe inserts. This exclusion does not apply to preventive foot care if you have diabetes, and to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

7. Arch supports. This exclusion does not apply to preventive foot care if you have diabetes, and to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

## G. Medical Supplies and Equipment

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

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

   This exclusion does not apply to:

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

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*

3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.

4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

## H. Nutrition

1. Nutritional counseling that is non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to nutritional counseling services as described under *Introduction* in *Section 1: Covered Health Care Services*, *When are Benefits Available for Covered Health Care Services*?

2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*. This exclusion does not apply to enteral feedings required for the treatment of inherited metabolic disorder for which Benefits are

provided as described in the *Outpatient Prescription Drug Rider*. See the Benefits for medical foods described under the *Outpatient Prescription Drug Rider*.

3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. See the Benefits for eosinophilic gastrointestinal disorder formula described under the *Outpatient Prescription Drug Rider*.

## I. Personal Care, Comfort or Convenience

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

- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

## J. Physical Appearance

1. Procedures or services that are not reconstructive:
   - 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.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
2. Cosmetic Procedures unless considered reconstructive as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

   For Cosmetic Procedures see the definition in *Section 9: Defined Terms*. Examples may include:
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
   - Abdominoplasty.
   - Blepharoplasty.
   - Body contouring.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Mastopexy.
   - Pectoral implants.
   - Rhinoplasty.
   - Skin resurfacing.
3. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive

if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

4. Treatment of benign gynecomastia (abnormal breast enlargement in males).
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
7. Wigs regardless of the reason for the hair loss.

## K. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Habilitative services for maintenance/preventive treatment.
6. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
7. Biofeedback.
8. Services for the evaluation and treatment of TMJ, whether the services are considered to be medical or dental in nature. This exclusion does not apply to orthognathic surgery for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Care Services*.
9. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment. This exclusion does not apply to orthognathic surgery for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Care Services*.
10. Surgical and non-surgical treatment of obesity.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.* This exclusion does not apply to breast reduction surgery for treatment of Gender Dysphoria.
13. Helicobacter pylori *(H. pylori)* serologic testing.
14. Intracellular micronutrient testing.

15. Cellular Therapy, Gene Therapy, and other genetic/molecular therapies not received from a Designated Provider. This exception does not apply to therapies in which Benefits are provided as described under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services*.

## L. Providers

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

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

   This exclusion does not apply to mammography.

## M. Reproduction

1. The following infertility treatment-related services:

   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services.

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

   - All costs related to reproductive techniques including:
     - Assisted Reproductive Technology (ART).
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
     - Preimplantation Genetic Testing (PGT) and related services.

     The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

     This exclusion does not apply when a child is legally adopted by a Subscriber after birth through a Surrogate who is not a Covered Person, when the adoption coverage criteria is met as described under Section 1: Covered Health Care Services, Pregnancy - Maternity Services.
   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
     - Surrogate insurance premiums.

- Travel or transportation fees.

3. Costs of donor eggs and donor sperm.
4. The reversal of voluntary sterilization.
5. Elective fertility preservation.
6. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of infertility. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

## N. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

## O. Transplants

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

## P. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. This exclusion does not apply to the following:
   - Preauthorized Covered Health Care Services from a Designated Provider that require you to travel outside of the Service Area.
   - Ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services*.
   - Travel expenses for which Benefits are provided when you receive a Covered Health Care Service from an out-of-Network provider as a result of an Emergency or if we refer you to an out-of-Network provider. We will reimburse the out-of-Network provider for any out-of-

Network cost that you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider.

## Q. Types of Care, Supportive Services, and Housing

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing or inpatient private room except when determined Medically Necessary.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of Personal Care Aides.
8. Independent living services.
9. Assisted living services.
10. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act.*
11. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
12. Transitional Living services (including recovery residences).

## R. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix 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:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

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

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions. Benefits for bone anchored hearing aids are provided as described under *Hearing Aids* in *Section 1: Covered Health Care Services*.
6. Over-the-counter hearing aids.

## S. All Other Exclusions

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

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

2. Physical, psychiatric or psychological exams, testing or treatments that are otherwise covered under the Policy when:

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

   Vaccinations and immunizations required as a prerequisite for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, travel, licensure, certification, registration, sports or recreational activities unless such immunizations are also considered preventative care.

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

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

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

6. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.

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

8. Autopsy.

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

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

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original

disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

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

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

# Section 3: When Coverage Begins

## How Do You Enroll?

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

## What If You Are Hospitalized When Your Coverage Begins?

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

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

These Benefits will be paid subject to coordination of benefits with your prior carrier.

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

## Who Is Eligible for Coverage?

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

### Eligible Person

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

Eligible Persons must live or work within the Service Area.

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

### Dependent

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

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

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

## When Do You Enroll and When Does Coverage Begin?

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

## Initial Enrollment Period

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

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

## Open Enrollment Period

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

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

## New Eligible Persons

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

Coverage for a newborn child, adopted child or a child placed for adoption begins on the date of birth, adoption, placement for adoption and will remain in effect for 31 days. If payment of additional Premium is required in order to provide coverage for the child, the Subscriber must notify us of the event and pay any additional required Premium within 31 days of the event in order to continue coverage beyond the initial 31 day period.

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

## Special Enrollment Period Required by Federal Law

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period as required by Federal law.

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

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

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

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period or the Eligible Person or Dependent is employed by an employer that offers multiple health benefit plans and the person elected a different plan during Open Enrollment; and
- Coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including termination of employment, reduction in the number of hours of employment, legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

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

# Section 4: When Coverage Ends

## General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy. We will provide at least sixty (60) days advance written notice to the Subscriber that coverage will terminate or nonrenew on the date we identify in the notice.

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

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

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

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

## What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends, we are responsible for notifying you that your coverage has ended when it ends at the request of the Group, for the Group's failure to pay Premium, or for fraud on the part of the Group. We will provide at least sixty (60) days advance written notice to the Subscriber if the Policy is terminated or nonrenewed on the date we identify in the notice.

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the date the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

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

## Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least sixty (60) days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because the Group committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

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

## Coverage for a Disabled Dependent Child

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

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

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

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

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

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

## Extended Coverage for Total Disability

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

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

## Continuation of Coverage and Conversion

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

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

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

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

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

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

## Conversion

If your coverage under the Policy ends for one of the reasons described below, you may apply for conversion coverage under an individual conversion policy. The right to apply for conversion coverage applies to you if you are a Subscriber or an Enrolled Dependent.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the first Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Coverage provided by the conversion policy will provide Benefits most similar to the coverage included under this Policy.

# Section 5: How to File a Claim

## How Are Covered Health Care Services from Network Providers Paid?

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

If you receive a bill from a Network provider for non-Covered Health Care Services, you are responsible for the bill you receive directly from the Network provider. Your right to Benefits under this Policy is limited to Covered Health Care Services as described under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*. If you choose to obtain services, treatments, items or supplies from a Network provider that are not Covered Health Care Services under *Section 1: Covered Health Care Services* or specifically excluded in *Section 2: Exclusions and Limitations*, you are accepting financial responsibility for those services.

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

You must obtain Covered Health Care Services from a Network provider except for Emergency Health Care Services or in cases when UnitedHealthcare refers you to an out-of-Network provider.

If you receive Emergency Health Care Services from an out-of-Network provider you should show your identification card (ID) or inform the provider that you have coverage under a UnitedHealthcare of Arizona, Inc. Policy. Generally, the out-of-Network provider will contact us to verify eligibility and coverage information.

If you receive a Covered Health Care Service from an out-of-Network provider as a result of an Emergency or if we refer you to an out-of-Network provider, we will reimburse the out-of-Network provider for any out-of-Network cost you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider.

You should not pay the out-of-Network provider directly for Emergency Health Care Services with the exception of any Co-payment and/or Co-insurance you are responsible for paying under the Policy. However, if you receive Covered Health Care Services from an out-of-Network provider for Emergency Health Care Services and you paid the out-of-Network provider directly, we will reimburse you for the Allowed Amount.

### Payment of Benefits

All Allowed Amounts due to a provider will be paid directly to the provider instead of being paid to the Subscriber, except when the Subscriber paid an out-of-Network provider directly to the provider.

You may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of such payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

- Is not an assignment of your Benefits under the Policy or of any legal or equitable right to institute any proceeding relating to your Benefits,
- Is not a waiver of the prohibition on assignment of Benefits under the Policy, and
- Will not preclude us from asserting that any purported assignment of Benefits under the Policy is invalid and prohibited.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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

# Section 6: Questions, Complaints and Appeals

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

## What if You Have a Question?

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

## Appeals and Grievance Process

You may participate in UnitedHealthcare's appeals and grievance process. Our appeals and grievance process is explained in detail in the UnitedHealthcare *Health Care Insurer Appeals Process Information Packet.* The *Health Care Insurer Appeals Process Information Packet* will be provided to you as follows:

- **Upon Initial Enrollment**: A copy of the *Health Care Insurer Appeals Process Information Packet* will be attached to your *Certificate of Coverage* upon initial enrollment.
- **When Your Health Plan Coverage is Renewed**: When your coverage under the Policy is renewed, we will send you a separate statement with your *Certificate of Coverage* to remind you that you can request to receive another copy of the *Health Care Insurer Appeals Process Information Packet* by calling the telephone number on the back of your ID card.
- **Upon Your Request or Your Treating Provider's Request**: You or your treating provider may obtain a copy of the *Health Care Insurer Appeals Process Information Packet* at any time by calling the telephone number on the back of your ID card or our *Appeals Department* at 1-800-442-4199.
- **On our website**: You can obtain access of a copy of The *Health Care Insurer Appeals Process Information Packet* on our website at www.uhc.com/legal/required-state-notices/arizona.

# Section 7: Coordination of Benefits

## Benefits When You Have Coverage under More than One Plan

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

## When Does Coordination of Benefits Apply?

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

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

## Definitions

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

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

   1. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group contracts; and Medicare or other governmental benefits, as permitted by law.

   2. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies, Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

B. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Care Coverage Plan's benefits.

C. "Allowable Expense" means any necessary, reasonable and customary item of expense at least a portion of which is covered under one or more of the Coverage Plans covering the person for whom claim is made or service is provided. When a Coverage 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 of service that is not covered by any of the Coverage Plans is not an Allowable Expense.

A Coverage Plan that takes Medicare or similar government benefits into consideration when determining the application of the coordination of benefits provision does not expand the definition of an allowable expense.

D. "Claim Determination Period" means a calendar year. However, it does not include any part of a year in which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

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

F. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that uses an order of benefit determination provision which is inconsistent with this regulation is called a non-complying plan. A Coverage Plan that complies with this provision, called a complying plan, may coordinate its benefits with a non-complying plan. If the complying plan is the primary Coverage Plan, it will pay or provide its benefits on a primary basis. If the complying plan is the Secondary Coverage Plan, it will pay or provide its benefits first as the Secondary Coverage Plan.

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

D. The first of the following rules that describe which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

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

2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier by month or day of the year if:

1) The parents are married;

2) The parents are not separated (whether or not they ever have been married); or

3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses of health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rules applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

1) The Coverage Plan of the custodial parent

2) The Coverage Plan of the spouse of the custodial parent

3) The Coverage Plan of the noncustodial parent

d. If one of the Coverage Plans is used outside the state of Arizona and it determines the order of benefits based upon the gender of a parent, and if, as a result, the plans do not agree on the order of benefits, the Coverage Plan with the gender rule shall determine the order of benefits.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee.

If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).

4. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

## Effects of Benefits on this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Coverage 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 Coverage Plan. The Secondary Coverage Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Coverage 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 Coverage 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 Coverage Plan and other Coverage 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 Coverage Plan and other Coverage 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 Coverage 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 Coverage Plan may include an amount that should have been paid under this Coverage 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 Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. Except in cases of fraud, we will not adjust or request adjustment of the payment of a claim more than one year after we have paid the claim.

# Section 8: General Legal Provisions

## What Is Your Relationship with Us?

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

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

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

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

## What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

## What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

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

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

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

## Notice

We provide written notice regarding administration of the Policy to an authorized representative of the Group and to all affected Subscribers.

## Statements by Group or Subscriber

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

## Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us

includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above.

## Are Incentives Available to You?

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

## Do We Receive Rebates and Other Payments?

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

## Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

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

## Who Provides Administrative Services?

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

## Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy. We will provide the Group and all affected Subscribers with 60 days prior notice of changes to the Policy that would be effective on the anniversary date of the Policy.

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

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

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

## How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

## Do We Require Examination of Covered Persons?

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

## Is Workers' Compensation Affected?

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

## When Do We Receive Refunds of Overpayments?

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

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

The refund equals the amount we paid in excess of the amount we should have paid under the Policy.

## Important Notice - Third Party Payers

When there is a third party source of payment such as a liability insurer, a government payer, or any uninsured and/or underinsured motorist coverage, Network providers may be entitled to collect from the third parties. They may be entitled to collect any difference between the Allowed Amount that we pay and the Network providers' customary charges, pursuant to *A.R.S. 33-931*. Arizona law prohibits providers from charging you more than the Co-payment and any deductible you are required to pay as described in this *Certificate of Coverage.*

## Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. In the interest of saving time and money, you are encouraged to first complete all steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*.

If you want to bring a legal action against us you must do so within three years from the applicable date specified below or you lose any rights to bring such an action against us:

- The date of expiration of the time period in which a request for reimbursement must be submitted.
- The date we notified you of our final decision on your appeal.

## What Is the Entire Policy?

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

# Section 9: Defined Terms

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

- Rotary wing Air Ambulance means transportation by a helicopter that is certified as an ambulance and such services and supplies as may be Medically Necessary.
- Fixed wing Air Ambulance means transportation by a fixed wing aircraft that is certified as a fixed wing air ambulance and supplies as may be Medically Necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Congenital Anomaly** - a physical developmental defect that is present at the time of birth.

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

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

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

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

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

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

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

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

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or

maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

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

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

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

The following conditions apply:

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

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month during which the child reaches age 26.

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

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

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

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

**Designated Provider** - a provider and/or facility that:

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

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

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

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

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

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

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

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

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

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

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

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child), including mental health, in serious jeopardy;
- Serious impairment to bodily function of the Covered Person;
- Serious dysfunction of any bodily organ or part of the Covered Person; or
- Harm to the Covered Person or others.

**Emergency Health Care Services** - with respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or

an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and

- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act,* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3)* of the *Social Security Act (42 U.S.C. 1395dd(e)(3))* which means to provide medical treatment for an Emergency as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

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

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

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

  d) Any other conditions as specified by the Secretary.

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

- Emergency Health Care Services do not require prior authorization.

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

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
   - *American Hospital Formulary Service Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
   - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
   - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)

3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

4. Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

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

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

- This exclusion will not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:
    - The acceptable standard medical reference compendia are the following:
        - The *American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists.*
        - The *National Comprehensive Cancer Network Drugs and Biologics Compendium.*
        - *Thomson Micromedex Compendium DRUGDEX.*
        - *Elsevier Gold Standard's Clinical Pharmacology Compendium.*
        - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
    - Medical literature may be accepted if all of the following apply:
        - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
        - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
        - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to *Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).*

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

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

**Genetic Counseling** - counseling by a qualified clinician that includes:

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

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

**Genetic Testing** - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

**Gestational Carrier** - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

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

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

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

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

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

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

**Iatrogenic Infertility** - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

**Independent Freestanding Emergency Department** - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Care Services.

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

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

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

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

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

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

**Intensive Outpatient Program(s)** - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

**Intermittent Care** - skilled nursing care that is provided either:

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

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

**Manipulative Treatment (adjustment)** - the nonsurgical and noninvasive treatment of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of the chiropractic practice.

**Medically Necessary** - health care services that are all of the following as determined by us or our designee:

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

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

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

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

your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

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

**Mental Health Care Services** - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

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

**Mental Illness** - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by *the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by *the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

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

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services 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 Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

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

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

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

**Open Enrollment Period** - An annual period, usually occurring shortly before the beginning of a new plan year, during which Eligible Persons can enroll for benefits and change their elections under the Group's Policy. The Open Enrollment Period is effective based on the date agreed upon between the Group and us.

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

**Out-of-Pocket Limit** - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

**Partial Hospitalization/Day Treatment/High Intensity Outpatient** - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

**Personal Care Aides** - an unlicensed provider of basic services such as helping with non-medical activities of daily living, cleaning, organizing, etc.

**Pharmaceutical Product(s)** - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

**Physician** - any provider who is properly licensed and qualified by law to provide services that are within the lawful scope of practice of Physician (as defined by Arizona law).

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

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

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

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

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

**Pregnancy** - includes all of the following:

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

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

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

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

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

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

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

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

**Recognized Amount -** the amount which Co-payment, Co-insurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers. This definition will apply when you obtain a Covered Health Care Service in the following circumstances:

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

The amount is based on the lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

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

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

**Remote Physiologic Monitoring** - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health care professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

**Residential Treatment** - a program of Mental Health Care Services or Substance-Related and Addictive Disorders Services that meets all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:

- Room and board.
- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

**Residential Treatment Facility** - a Hospital or facility that provides Residential Treatment that is licensed and operated as required by law.

**Rider** - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

**Secretary** - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

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

**Shared Savings Program** - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider and a third party vendor. When this program applies, the out-of-Network provider's billed charges will be discounted. Co-insurance and any applicable deductible would still apply to the reduced charge. Our policy provisions or administrative practices may supersede the scheduled rate. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.
- The median amount negotiated with Network providers for the same or similar service.

In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card for assistance with resolving that issue. Shared Savings Program providers are not Network providers and are not credentialed by us.

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

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

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.

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

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

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

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

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

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

**Surrogate** - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

**Total Disability or Totally Disabled** - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities in light of his/her age, education, training, experience, station in life, physical and mental capacity.

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

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

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

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

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

Please note:

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

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

# Section 10: Consolidated Appropriations Act Summary

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act") (P.L. 116-260)*.

## No Surprises Act

### Balance Billing

Under the Act, the *No Surprises Act* prohibits balance billing by out-of-Network providers in the following instances:

- When Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- When non-Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When Emergency Health Care Services are provided by an out-of-Network provider.
- When Air Ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment, Co-insurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a Network provider and is determined based on the Recognized Amount.

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

### Determination of Our Payment to the Out-of-Network Provider:

When Covered Health Care Services are received from out-of-Network providers for the instances as described above, Allowed Amounts, which are used to determine our payment to out-of-Network providers, are based on one of the following in the order listed below as applicable:

- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

### Continuity of Care

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

If we terminate a contractual relationship with a Network Physician or health care facility while you are a continuing care patient (except for terminations due to failure to meet applicable quality standards or for

fraud), we will notify you of the termination and your right to elect continued transitional care from the terminated Physician or health care facility and permit you to continue the course of treatment furnished by the terminated Physician or health care facility relating to the continuing transitional care under the same terms and conditions as would have applied if the contract had not been terminated, until the earlier of 90-days or the date on which you are no longer a continuing care patient with respect to the terminated Physician or health care facility.

A continuing care patient means an individual who:

- Is undergoing a course of treatment for a serious and complex condition from the terminated Physician or health care facility;
- Is undergoing a course of institutional or inpatient care from the terminated Physician or health care facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from the terminated Physician or health care facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the terminated Physician or health care facility; or
- Is or was determined to be terminally ill and is receiving treatment for such illness from such terminated Physician or health care facility.

A serious and complex condition is:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

If you are a new enrollee and currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. In addition to the situations require for ensured continuity of care under the *Consolidated Appropriations Act*, Arizona law requires that we allow any new enrollee whose health care provider is not part of our Network, on written request from the new enrollee to us, to continue an active course of treatment with that health care provider during a transitional period after the effective date of the enrollment if both of the following apply:

If you have either:

- A life-threatening disease or condition, in which case the transitional period is not more than thirty days after the effective date of the enrollment.
- Entered the third trimester of pregnancy on the effective date of the enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery, **and**

Your treating provider agrees in writing to do all of the following:

- Except for Co-payment, Co-insurance or deductible amounts, accept as payment in full reimbursement from us at the rates that are established by us and that are not more than the level of reimbursement applicable to similar services by health care providers within the Network.
- Comply with our quality assurance and utilization review requirements and provide us with any necessary medical information related to the care.
- Comply with our policies and procedures relating to continuity of care including procedures relating to referrals and obtaining preauthorization, claims handling and treatment plan approval by us.

## Provider Directories

The Act provides that if you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a Network provider.

# Outpatient Prescription Drug

# UnitedHealthcare of Arizona, Inc.

# Schedule of Benefits

## When Are Benefits Available for Prescription Drug Products?

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

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

## Benefits for Oral Chemotherapeutic Agents

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

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

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

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

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular reference product.

## How Do Supply Limits Apply?

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

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed. For Prescription Drug Products that allow a 90-day fill, you may be required to obtain a limited number of up to 31-day fills until the maintenance dose is established.

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

## Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior

authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

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

**Network Pharmacy Prior Authorization**

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

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

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

A prior authorization request, once granted or deemed granted, is binding on us, may be relied on by you and your Physician or pharmacist and may not be rescinded or modified by us or our utilization review agent after the Physician or pharmacist renders the Prescription Drug Product or Covered Health Care Service in good faith and pursuant to the authorization unless there is evidence of fraud or misrepresentation by the Physician or pharmacist.

## Does Step Therapy Apply?

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

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

## What Do You Pay?

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

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

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

## Prescription Drug Product Cost Sharing Accumulation

Any Co-payment, Co-insurance, or other applicable cost sharing requirement for pharmacy Benefits paid by the Covered Person or another person on behalf of the Covered Person will contribute toward the calculation of a Covered Person's Out-of-Pocket Limit and Deductible.

## Exception Process for PPACA Zero Cost Share Preventive Contraceptives and HIV PrEP Medications and Related Services

You and your provider may request an exception for contraceptives and HIV PrEP medications and related services that are not part of the PPACA Zero Cost Share Preventive Care Medications. We may require the provider to submit clinical documentation as part of the exception request. Please call us at the telephone number on your ID card to request an exception.

## Payment Information

| Payment Term And Description | Amounts |
|---|---|
| **Co-payment and Co-insurance** | |
| ***Co-payment***<br><br>Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.<br><br>***Co-insurance***<br><br>Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.<br><br>***Co-payment and Co-insurance***<br><br>Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.<br><br>We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.<br><br>Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card.<br><br>**Special Programs:** We may have certain programs in which you may receive a reduced Co-payment and/or | For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:<br><br>• The applicable Co-payment and/or Co-insurance.<br>• The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.<br>• The Prescription Drug Charge for that Prescription Drug Product.<br><br>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:<br><br>• The applicable Co-payment and/or Co-insurance.<br>• The Prescription Drug Charge for that Prescription Drug Product.<br><br>See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.<br><br>You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications, including certain contraceptives and HIV PrEP medications and related services.<br><br>You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Preventive Medications.<br><br>You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications. The List of Zero Cost Share Medications includes certain Prescription Drug Products under these drug classes or categories:<br><br>• Insulins.<br>• Epinephrine.<br>• Glucagon.<br>• Naloxone.<br>• Albuterol inhalers and nebulized solutions.<br><br>Please Note: Not all Prescription Drug Products under these drug classes or categories may be covered on the List of Zero Cost Share Medications.<br><br>You may find out if a Prescription Drug Product is on the List of Zero Cost Share Medications by contacting us at |

| Payment Term And Description | Amounts |
| --- | --- |
| Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. If a program provides incentives for meeting certain criteria, we will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.<br><br>**Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills.<br><br>**Variable Co-payment Program**:<br><br>Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a coupon based on the value of the coupon used. Pharmaceutical manufacturer or affiliates determine the value of their coupons. Contact www.myuhc.com or the telephone number on your ID card for an available list of Prescription Drug Products and the applicable Co-payment and/or Co-insurance.<br><br>**Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at | www.myuhc.com or the telephone number on your ID card. |

| Payment Term And Description | Amounts |
| --- | --- |
| www.myuhc.com or the telephone number on your ID card.<br><br>**NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. | |

## Benefit Information

| **The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.** | |
|---|---|
| **Description and Supply Limits** | **What Is the Co-payment or Co-insurance You Pay?**<br>**This May Include a Co-payment, Co-insurance or Both** |
| **Eosinophilic Gastrointestinal Disorder Formula**<br>Benefits for Eosinophilic Gastrointestinal Disorder Formula are subject to payment of the Annual Drug Deductible in high deductible health plans only. | You pay 25% of the Prescription Drug Charge per Prescription Order or Refill for Eosinophilic Gastrointestinal Disorder Formula. |
| **Medical Foods**<br>Benefits for Medical Foods are subject to payment of the Annual Drug Deductible in high deductible health plans only. | You pay 50% of the Prescription Drug Charge per Prescription Order or Refill for Medical Foods to treat an Inherited Metabolic Disorder. |
| **Specialty Prescription Drug Products** | |
| The following supply limits apply.<br>• As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program.<br>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.<br>If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.<br>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated | Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement.<br>For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill.<br>For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $35 per Prescription Order or Refill.<br>For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $70 per Prescription Order or Refill. |

| **The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.** | |
|---|---|
| **Description and Supply Limits** | **What Is the Co-payment or Co-insurance You Pay?**<br>**This May Include a Co-payment, Co-insurance or Both** |
| Pharmacy. | |
| **Prescription Drugs from a Retail Network Pharmacy** | |
| The following supply limits apply:<br>• 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.<br>• A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied.<br>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. | Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.<br>For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill.<br>For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $35 per Prescription Order or Refill.<br>For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $70 per Prescription Order or Refill. |
| **Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy** | |
| The following supply limits apply:<br>• As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order | Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.<br>For up to a 90-day supply at a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you pay:<br>For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $25 per Prescription Order or Refill.<br>For a Tier 2 Prescription Drug Product: None of the |

| **The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.** | |
|---|---|
| **Description and Supply Limits** | **What Is the Co-payment or Co-insurance You Pay?**<br>**This May Include a Co-payment, Co-insurance or Both** |
| Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.<br><br>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 Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills. | Prescription Drug Charge after you pay $87.50 per Prescription Order or Refill.<br><br>For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $175 per Prescription Order or Refill. |

# Outpatient Prescription Drug Rider

# UnitedHealthcare of Arizona, Inc.

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

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

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

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

UnitedHealthcare of Arizona, Inc.



Heather Kane, President and CEO

# Introduction

## Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

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

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

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

## Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

## 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 do not obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

*Smart Fill Program - Split Fill*

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

## When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

## Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. We may pass a portion or all of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

## Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

## Variable Co-payment Program

Certain Prescription Drug Products, including Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary based on the value of the coupon used. Pharmaceutical manufacturer or affiliates determine the value of their coupons. Please contact www.myuhc.com or the telephone number on your ID card for an available list of Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits*.

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

## Price Edge Cost List

The *Price Edge Cost (PEC) List* is a list of Generic Prescription Drug Products that will be covered at a price level that we establish when a Prescription Drug Product is obtained from retail Network Pharmacy or a mail order Network Pharmacy as described below. This list is subject to our review and may change from time to time. When a Generic Prescription Drug Product is included on the *PEC List* and is dispensed by a retail Network Pharmacy or a mail order Network Pharmacy, the *PEC List* price will only apply when the *PEC List* price is the lowest cost option for the Covered Person. You may access the amount you will pay for Prescription Drug Products to be dispensed by a retail Network Pharmacy or a mail order Network Pharmacy by contacting us at www.myuhc.com or the telephone number on your ID card.

## Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. If a program provides incentives for meeting certain criteria, we will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

## Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications.

## Prescription Drug Products Prescribed by a Specialist

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

## Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. You may access information on these procedures through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

## Benefits for Refills for Prescription Eye Drops to Treat Glaucoma or Ocular Hypertension

Benefits include refills of a prescription for eye drops to treat glaucoma or ocular hypertension if the following apply:

- You request the refill:
  - For a 30-day supply, at least 23 days but not less than 33 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.
  - For a 60-day supply, at least 45 days but not less than 60 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.

    - For a 90-day supply, at least 68 days but not less than 90 days from the later of:
        - The original date the prescription was distributed to you.
        - The date of the most recent refill was distributed to you.
- The eye drops to treat glaucoma or ocular hypertension prescribed by the provider are a Covered Health Care Service under the Policy.
- The prescribing provider indicates on the original prescription that additional quantities of the eye drops are needed.
- The refill requested by you does not exceed the number of additional quantities prescribed.

## Exception Process for PPACA Zero Cost Share Preventive Contraceptives and HIV PrEP Medications and Related Services

You and your provider may request an exception for contraceptives and HIV PrEP medications and related services that are not part of the PPACA Zero Cost Share Preventive Care Medications. We may require the provider to submit clinical documentation as part of the exception request. Please call us at the telephone number on your ID card to request an exception.

# Outpatient Prescription Drug Rider Table of Contents

**Section 1: Benefits for Prescription Drug Products .....16**
**Section 2: Exclusions .....17**
**Section 3: Defined Terms .....21**
**Section 4: Your Right to Request an Exception for Contraceptives ...25**

# Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception. Benefits are also available for Preventive Care Medications as defined in *Section 3: Defined Terms* and include, but are not limited to, over-the-counter aspirin in accordance with the current recommendations of the *United States Preventive Services Task Force* and prescribed by a Network provider.

**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. Please see *Designated Pharmacies* above.

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

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

**Prescription Drugs from a Retail Network Pharmacy**

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

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

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

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

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

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

# Section 2: Exclusions

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

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

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:
    - The acceptable standard medical reference compendia are the following:
        - The *American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.
        - The *National Comprehensive Cancer Network Drugs and Biologics Compendium*.
        - *Thomson Micromedex Compendium DRUGDEX*.
        - *Elsevier Gold Standard's Clinical Pharmacology Compendium*.
        - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
    - Medical literature may be accepted if all of the following apply:
        - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
        - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
        - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to *Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).*

7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which 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.

9. Any product dispensed for the purpose of appetite suppression or weight loss.

10. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

11. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

12. General vitamins, except the following, which require a Prescription Order or Refill:

    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

13. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as (a) unit dose(s).

14. Prescription Drug Products used for cosmetic or convenience purposes.

15. Prescription Drug Products, including New Prescription Drug Products, that we determine do not meet the definition of a Covered Health Care Service.

16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

17. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA*-approvedbulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3.)

18. The following over-the-counter drugs and products:

    - Drugs or products available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter drug or product as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. This exclusion does not apply to aspirin, over-the-counter contraceptives for women, or all other *United States Preventive Services Task Force* "A" and "B" recommended over-the-counter medications and supplements when prescribed by a Network provider. You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations.
    - Over-the-counter continuous glucose monitors; and

    The following Prescription Drug Products with over-the-counter alternatives:

- Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year.
- Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year.

We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. Certain New Prescription Drug Products until the date they are reviewed and placed on a tier by our PDL Management Committee and applicable clinical criteria are approved.
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, and prescription medical food products even when used for the treatment of Sickness or Injury, except for Eosinophilic Gastrointestinal Disorder Formula or for Medical Foods prescribed for the treatment of Inherited Metabolic Disorder in *Section 3: Defined Terms* of this *Rider*.
22. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
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 or Pharmaceutical Product as described in the *Certificate*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another Prescription Drug Product or Pharmaceutical Product as described in the *Certificate* available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Certain Prescription Drug Products that have not been prescribed by a Specialist.
26. A Prescription Drug Product that contains marijuana, including medical marijuana.
27. Dental products, including but not limited to prescription fluoride topicals.
28. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

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

29. Diagnostic kits and products, including associated services.

30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill, including Digital Therapeutics. This exclusion does not apply to Digital Therapeutics for which Benefits are provided as described under *Preventive Care Services* in your *Certificate*

31. Certain Prescription Drug Products that are *FDA*-approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

32. Prescription Drug Products prescribed by a provider who is on our list of excluded providers due to fraud, waste, and/or abuse findings.

# Section 3: Defined Terms

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

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

**Designated Pharmacy** - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

**Digital Therapeutics** - *U.S. Food and Drug Administration (FDA)*-approved or cleared therapeutic interventions driven by software or digital technology to prevent, diagnose, monitor, or treat a Sickness, Injury, or Mental Illness.

**Eosinophilic Gastrointestinal Disorder Formula** - amino acid-based formula used in the treatment of a Covered Person who has been diagnosed as having an Eosinophilic Gastrointestinal Disorder, subject to the following conditions:

- The Covered Person must be under the continuous supervision of a Physician who is licensed under *Title 32, Chapter 13 or 17 of the Arizona Revised Statutes* or a registered nurse practitioner who is licensed under Title 32, Chapter 15 of the Arizona Revised Statutes.
- The formula must be prescribed or ordered by a Physician or a registered nurse practitioner.
- There must be a risk of mental or physical impairment to the Covered Person without the use of the formula.

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

**Inherited Metabolic Disorder** - a disease or disorder caused by an inherited abnormality of body chemistry, including a disease or disorder tested under the newborn screening program:

- Which involves amino acid, carbohydrate and fat metabolism.
- For which medically standard methods of diagnosis, treatment, and monitoring exist.
- Which requires specifically processed or treated Medical Foods that are generally available only under the supervision and direction of a Physician or a registered nurse practitioner with special training in the diagnosis and treatment of patients with genetic inborn errors of metabolism and that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

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

**List of Zero Cost Share Medications** - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

Please Note: Not all Prescription Drug Products under these drug classes or categories may be covered on the List of Zero Cost Share Medications.

The above drug classes or categories are subject to our review and change from time to time. You may find out if a Prescription Drug Product is on the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

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

**Medical Foods** - modified nutritional substances in any form that are all of the following:

- Used in the treatment of Inherited Metabolic Disorders to compensate for the metabolic abnormality and to maintain adequate nutritional status.
- Formulated to be consumed or administered enterally under the supervision of a Physician or a registered nurse practitioner.
- Specifically processed or formulated to be deficient in one or more nutrients present in typical foodstuffs. This does not include a natural food or food product that is naturally low in protein.
- Intended for the medical and nutritional management of patients who have limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation.
- Essential to optimize growth, health, and metabolic homeostasis.

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

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

**PPACA** - Patient Protection and Affordable Care Act of 2010.

**PPACA Zero Cost Share Preventive Care Medications** - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible,

Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including items and services for prevention of human immunodeficiency virus (HIV) infection.
- Certain immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices for Disease Control and Prevention*.
- 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 *FDA* approved methods of female contraception. You may view the list of contraceptives recommended by the *FDA* at **https://www.fda.gov/consumers/free-publications-women/birth-control-chart**. If you do not have internet access, please call us at the telephone number on your ID card.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

- **Exception Process for PPACA Zero Cost Share Preventive Contraceptives and HIV PrEP Medications and Related Services**

  You and your provider may request an exception for contraceptives and HIV PrEP medications and related services that are not part of the PPACA Zero Cost Share Preventive Care Medications. We may require the provider to submit clinical documentation as part of the exception request. Please call us at the telephone number on your ID card to request an exception.

**Preferred 90 Day Retail Network Pharmacy** - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

**Prescription Drug Charge** - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

**Prescription Drug List** - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. The Prescription Drug List is developed through an evidence-based evaluation when determining which Prescription Drug Products are covered or excluded under the Policy. Medications may be excluded from coverage when it works the same or similar as another prescription medication or an over-the-counter medication. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
    - blood glucose monitors;
    - blood glucose monitors for the legally blind;
    - test strips for glucose monitors and visual reading and urine testing strips;
    - insulin preparations and glucagon;
    - insulin cartridges;
    - drawing up devices and monitors for the visually impaired;
    - injection aids;
    - insulin cartridges for the legally blind;
    - syringes and lancets, including automatic lancing devices;
    - prescribed oral agents for controlling blood sugar; and
    - any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999.

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

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

**Therapeutically Equivalent** - when Prescription Drug Products or Pharmaceutical Products as described in the *Certificate* have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

# Section 4: Your Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by us, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information please visit www.uhcprovider.com under the following path: *Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act $0 Cost-Share Preventive Medications Exemption Requests (Commercial Members)*.

# Doula Support Program Rider

# UnitedHealthcare of Arizona, Inc.

This Rider to the Policy is issued to the Group and provides a Covered Person with an allowance related to doula support as described below.

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

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

## Doula Support Program

The Doula Support Program provides an allowance for a Covered Person for the purpose of providing physical, informational, and emotional doula support during the Covered Person's pregnancy, childbirth, and the postpartum period. Services are only available for a Covered Person who is pregnant.

This program provides an allowance for incurred doula support expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $1,500 per Covered Person per pregnancy will be provided for doula support.

For the purposes of this Rider, "doula support" means physical, informational, and emotional support provided directly by the doula.

If you would like additional information regarding the Doula Support Program, you may contact us at www.myuhc.com or the telephone number on your identification card (ID) card.

UnitedHealthcare of Arizona, Inc.



Heather Kane, President and CEO

# Real Appeal Rider

# UnitedHealthcare of Arizona, Inc.

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

## Real Appeal

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

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

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

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

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

UnitedHealthcare of Arizona, Inc.



Heather Kane, President and CEO

# UnitedHealthcare Rewards Rider

# UnitedHealthcare of Arizona, Inc.

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards program.

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

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Arizona, Inc. When we use the words "you" and "your" we are referring to the Subscriber or their Enrolled Dependent spouse.

## UnitedHealthcare Rewards Program

The Group has implemented a program that rewards you for completing certain criteria, as described below. You may choose to complete any, or all, of the below criteria to earn a reward.

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

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your or distributed in other incentive types as applicable, administered by us.
- A device credit.
- Another type of incentive to help encourage you to participate in the program, administered as determined by us.

**Activity Targets**

You may also receive a reward when you meet one or more of the activity targets listed below, based on the device you choose to track activity.

| Activity Marker | Activity Target | Reward |
|---|---|---|
| **Participation - Fitness** | 15 minutes of activity as designated by the program or 5,000 steps per day | You can earn rewards for one or multiple activity markers. |
| **Active - Fitness** | 30 minutes or more of activity as designated by the program or 10,000 or more steps per day | |
| **Other Actions and/or Activities** | One or more actions and/or activities defined by us and aimed at the following:<br>• Health education;<br>• Improving health;<br>• Maintaining health; or<br>• Administrative objectives | |

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

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

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

**Rewards**

Rewards listed above, when earned, will be credited to a or distributed in other reward types as applicable, administered by us.

**Device**

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

UnitedHealthcare of Arizona, Inc.



Heather Kane, President and CEO

# Language Assistance Services

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-866-633-2446. (TTY: 711).

**ማሳሰቢያ**፦ **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በ 1-866-633-2446 ይደውሉ።

**لاحظة**: إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم 1-866-633-2446.

**দেখুন**: আপনি যদি **বাংলায় (Bengali-Bangala)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো, অন্যান্য ফরম্যাটে বিনামূল্যে যোগাযোগগুলি, আপনার জন্য উপলব্ধ। 1-866-633-2446 এ কল করুন।।

**ចំណាំ**៖ ប្រសិនបើអ្នកនិយាយ **ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជា ពុម្ពអក្សរ ជំ មានសម្រាប់អ្នក។ ទូរសព្ទទៅលេខ 1-866-633-2446។

**ATENSHUN**: Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale toor kapetal. Ko yegili 1-866-633-2446.

**ATENSYON**: Yanggen fifino' hao **CHamoru (Chamorro)**, guaha setbisio siha para hågu ni' fåtto, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha taiguihi i para mana'dångkolo i inemprenta. Ågang 1-866-633-2446.

**請注意**：如果您說**中文 (Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電1-866-633-2446。

**ATTENTION**: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le 1-866-633-2446.

**ATANSYON**: Si w pale **Kreyòl Ayisyen (French Creole-Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma ki disponib, tankou sa ki enprime ak gwo lèt yo. Rele 1-866-633-2446.

**ACHTUNG**: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie 1-866-633-2446an.

**ΠΡΟΣΟΧΗ**: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε 1-866-633-2446.

**ધ્યાન આપો**: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. 1-866-633-2446 પર કૉલ કરો.

**ध्यान दें**: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। कॉल करें 1-866-633-2446।

**LUS TSEEM CEEB**: Yog tias koj hais **Lus Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus pub dawb thiab muaj kev sib txuas lus dawb ua lwm hom ntawv, xws li luam ntawv loj rau koj. Hu rau: 1-866-633-2446.

**ATENSION**: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti 1-866-633-2446.

**ATTENZIONE**: se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero 1-866-633-2446.

**注意事項**：**日本語 (Japanese)** を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。1-866-633-2446にお電話ください。

**알림 사항**: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사소통 매체를 이용하실 수 있습니다. 1-866-633-2446번으로 전화해 주십시오.

**ໝາຍເຫດ**: ຖ້າຫາກທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ, ເຊັ່ນ: ການພິມຕົວອັກສອນຂະໜາດໃຫຍ່. ກະລຸນາໂທຫາ 1-866-633-2446.

**BAA'ÁKONÍNÍZIN**: **Diné (Navajo)** saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáá łahgo át'éego bee hadadilyaa bee ahxił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Kohjį' 1-866-633-2446 hodíilnih.

**ध्यान दिनुहोस्**: तपाईंले **नेपाली (Nepali)** बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा निःशुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। 1-866-633-2446 मा कल गर्नुहोस्।

**WICHDICH**: Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht, kenne mer dich Schprooch-Hilf un annri Sadde Schreiwes griege, so wie Grooss-Druck (large print), unni as es dich ennich eppes koschde zellt. Call 1-866-633-2446uff.

**توجه**: اگر به زبان **فارسی (Persian-Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با 1-866-633-2446 تماس بگیرید.

**UWAGA**: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod numer 1-866-633-2446.

**ATENÇÃO**: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para 1-866-633-2446.

**ਧਿਆਨ ਦਿਓ**: ਜੇ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। 1-866-633-2446 ਤੇ ਕਾਲ ਕਰੋ।

**ВНИМАНИЕ**! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по номеру 1-866-633-2446.

**FA'AALIGA**: Afai e te tautala i le **Faa-Samoa (Samoan-Fa'asamoa)**, o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Vala'au i le 1-866-633-2446.

**FIIRO GAAR AH**: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Wac 1-866-633-2446.

**ATENCIÓN**: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al 1-866-633-2446. (TTY 711).

**PAUNAWA**: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag sa 1-866-633-2446.

**โปรดทราบ** หากคุณ**พูดภาษาไทย (Thai)** ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทร 1-866-633-2446

**ЗВЕРНІТЬ УВАГУ**! Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як от набрані великим шрифтом. Телефонуйте на номер 1-866-633-2446.

**توجہ دیں**: اگر آپ **اردو (Urdu)** زبان بولتے ہیں تو زبان کی معاون خدمات اور دیگر فارمیٹس میں مواصلات، جیسے بڑے پرنٹ، آپ کے لیے مفت دستیاب ہیں۔ کال کریں 1-866-633-2446۔

**LƯU Ý**: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi 1-866-633-2446.

# Notice of Non-Discrimination

We[1] comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race color, national origin, age, disability or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, please call 1-866-633-2446 or the toll-free member phone number on your member ID card, TTY/RTT 711.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

If you need help filing a complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your member ID card, TTY/RTT 711.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

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

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

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

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.

[1]For purposes of this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

# Important Notices

## Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

## Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

## Notice of Transition of Care

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260),* group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

# Claims and Appeal Notice

***This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.***

## Benefit Determinations

### Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

### Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

## Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

## Concurrent Care Claims

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

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

## Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

## How Do You Appeal a Claim Decision?

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

Your request for an appeal should include:

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

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

## Appeal Process

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

## Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and your will be notified of the decision within 30 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

## Urgent Appeals that Require Immediate Action

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

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

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

# HEALTH PLAN NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## MEDICAL INFORMATION PRIVACY NOTICE

*Effective January 1, 2026:*

We[2] are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. We have the right to make any revised notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written, and electronic information to administer our business and to provide products, services, and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction, or misuse.

### How We Collect, Use, and Disclose Information

**We** collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to confirm we are meeting our privacy obligations.

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

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we share information with doctors to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we

may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsor**, if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**; however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information, such as age and gender, in risk rating and pricing, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders,** we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment, or health care operation messages using telephone numbers or email addresses you provide to us.

**We may** collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events, or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as needed to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions or services on our behalf if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information, including:

    1. Alcohol and Substance Use Disorder
    2. Biometric
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic
    6. HIV/AIDS
    7. Mental Health
    8. Minors
    9. Prescriptions
    10. Reproductive or Sexual Health
    11. Sexually Transmitted Diseases

We follow the more stringent law, where it applies to us. For example, if we receive information about you through a limited consent you provided to a federally-assisted substance use disorder treatment program ("Part 2 Program"), we will honor the permission you provide and continue to comply with *42 CFR Part 2*. If your consent permits our use and disclosure for all future treatment, payment, and health care operations purposes, we may use or disclose that information for those purposes and otherwise use and disclose that information in accordance with *the Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. In no event will we use or disclose your Part 2 Program information in legal proceedings

against you without your written consent or a court order after you have been notified and provided an opportunity to be heard.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For more information on how to revoke your authorization, call the phone number listed on your health plan ID card. Note that once your health information has been disclosed, it could be redisclosed by the recipient and no longer protected by federal privacy laws.

## What Are Your Rights

You have the following rights with respect to your health information:

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.

- **You have the right to a paper copy of this notice** at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request the deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

## Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want additional information about how to exercise your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** To exercise any of your rights described above. Mail your written requests to us at the following address:

UnitedHealthcare

*Customer Service - Privacy Unit*

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint or Grievance.** If you believe your privacy rights have been violated, you may file a complaint or grievance with us at the address listed above.

**You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

[2]This Health Plan Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; First Risk Advisors, Inc.; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; Healthplex Insurance Company; HealthSmart Primary Care Clinics, LP; International Healthcare Services, Inc.; MAMSI Life and Health Insurance Company; Managed Care of North America, Inc.; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; New Orleans Regional Physician Hospital Organization, L.L.C.; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Network, Inc.; Preferred Care Network of Florida, Inc.; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral

Health Plan, California; UHC of California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

# FINANCIAL INFORMATION PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.**

**PLEASE REVIEW IT CAREFULLY.**

*Effective January 1, 2026*

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

**Information We Collect**

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information, and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

**Disclosure of Information**

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

**Confidentiality and Security**

We maintain physical, electronic, and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction, or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

**Questions about this Notice**

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, on the last page of the Health Plan Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency;

Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

# Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

## Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

## Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

# ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

## Summary Plan Description

**Name of Plan:** University of Arizona Alternative Health Care Program

**Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:**

University of Arizona Alternative Health Care Program

888 N. Euclid Ave, Suite 217

Tucson, AZ 85721

(520) 621-3660

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

**Claims Fiduciary:** UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

**Employer Identification Number (EIN):** 74-2652689

**Plan Number:** 501

**Plan Year:** January 1 through December 31

**Type of Plan:** Health care coverage plan

**Name, Business Address, and Business Telephone Number of Plan Administrator:**

University of Arizona Alternative Health Care Program

888 N. Euclid Ave, Suite 217

Tucson, AZ 85721

(520) 621-3660

**Type of Administration of the Plan:** Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare of Arizona, Inc.

1 East Washington Street

Ste. 1700

Phoenix, AZ 85004

800-985-2356

**Person designated as Agent for Service of Legal Process:** Designated agent here

**Discretionary Authority of Plan Administrator and Other Plan Fiduciaries:** The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

**Source of Contributions and Funding under the Plan:** There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

**Method of Calculating the Amount of Contribution:** Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

**Qualified Medical Child Support Orders:** The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

**Amendment or Termination of the Plan:** Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.