Rocky Mountain Health Maintenance Organization, Incorporated

Individual Exchange Medical Policy

2775 Crossroads Boulevard

Grand Junction, CO 81506

888-809-6539

Colorado

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Your *Schedule of Benefits* and *Policy* are provided in the pages that follow.

Rocky Mountain Health Maintenance Organization, Incorporated

Individual Exchange Medical Policy

Agreement and Consideration

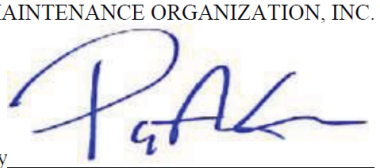
We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

ROCKY MOUNTAIN HEALTH
MAINTENANCE ORGANIZATION, INC.



By_____
Patrick Gordon, President and CEO

Rocky Mountain Individual Exchange

Rocky Mountain Health Maintenance Organization, Incorporated

Section 1: Schedule of Benefits (Who Pays What)

Covered Health Care Services Schedule of Benefits

RMHP Colorado Doctors Plan Bronze Essential ($0 Virtual Urgent Care, $5 Tier 2 Rx, $0 Insulin)

CO0001, $7,000

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician, who is located in the Network Area, in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a PCP. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the Network Area, for that child. If you do not select a Network Primary Care Physician for yourself or your Enrolled Dependent child, one will be assigned.

You may select any Network Primary Care Physician, who is located in the Network Area, and accepting new patients. You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that Provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child.

You can get a list of Network Primary Care Physicians and other Network Providers through www.myuhc.com/exchange or the telephone number on your ID card.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card or by going to www.myuhc.com/exchange. Changes are permitted once per month. Changes submitted on or before the last day of the month will be effective on the first day of the following month.

Network and Out-of-Network Benefits

To obtain Benefits, you must receive Covered Health Care Services from a Rocky Mountain Individual Exchange Benefit Plan Network provider. You can confirm that your provider is a Rocky Mountain Individual Exchange Benefit Plan Network provider through the telephone number on your ID card or you can access a directory of providers at www.myuhc.com/exchange. You should confirm that your provider is a Rocky Mountain Individual Exchange Benefit Plan Network provider, including when receiving Covered Health Care Services for which you received a referral from your Primary Care Physician.

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.

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

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

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

defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a Rocky Mountain 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, this *Schedule of Benefits* will control.

Care Management

There may be additional services that are available to you, such as disease management programs, discharge planning, health education, and patient advocacy. When you seek prior authorization for a Covered Health Care Service as required or are otherwise identified as meeting eligibility requirements for a care management program, we will work with you to engage in the care management process and to provide you with information about these additional services.

Does Prior Authorization Apply

We require prior authorization for certain Covered Health Care Services. Your Primary Care Physician and other 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. 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.

Payment Information

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.

NOTE: When Covered Health Care Services are provided by an Indian Health Service provider, your cost share may be reduced.

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. The Annual Deductible 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 Drugs* section. The Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Pediatric Vision Care Services* section.	$7,000 per Covered Person, not to exceed $14,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
Benefits for outpatient prescription drugs on the PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. 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.	
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 Drugs* section. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this Schedule of Benefits including the *Pediatric Dental Care Services* section and the *Pediatric Vision Care Services* section. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, when applicable. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	$9,450 per Covered Person, not to exceed $18,900 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable.	

Payment Term And Description	Amounts
Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

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 Policy, 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. Acupuncture			
Limited to 6 visits per year.	40%	Yes	Yes
2. Ambulance Services			
Emergency Ambulance Services 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:* 40%	Yes	Yes
	Air Ambulance: 40%	Yes	Yes
Non-Emergency Ambulance Transportation Ground or Air Ambulance, as we determine appropriate.	*Ground Ambulance:* 40%	Yes	Yes
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.*	*Air Ambulance:* 40%	Yes	Yes
3. Bariatric Surgery			

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 Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
4. 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 each Covered Health Care Service category in this *Schedule of Benefits*.		
5. Dental Anesthesia			
	40%	Yes	Yes
6. Diabetes Services			
Diabetes Self-Management and Educational Services For Covered Persons with Type 1 or Type 2 diabetes, the following services are offered at $0 cost share: • Retinal eye exams, limited to 1 exam per plan year. • Certain lab tests specifically used to assess lipid levels, kidney function (including metabolic and urine) and glucose control (HgbA1C) in diabetics. This does not apply to Covered Persons with pre-diabetes or gestational diabetes diagnoses.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Supplies Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management supplies will be the same as those stated under *Durable Medical Equipment (DME)* and in the *Outpatient Prescription Drugs s*ection. Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drugs* section.		

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 Policy, 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?**
Durable Medical Equipment (DME).			
7. Durable Medical Equipment (DME)			
You must purchase or rent the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	40%	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 48 hours or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from Emergent ER Services, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	50%	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 Policy, 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?**
9. Enteral Nutrition			
	40%	Yes	Yes
10. Gender Affirming Health Services			
It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drugs* section.		
11. Habilitative Services			
	Inpatient Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. Visit limits do not apply for therapies for Covered Persons with a primary diagnosis of Autism Spectrum Disorder.	*Outpatient* *Physical, Occupational, and Speech Therapies for the Treatment of Autism Spectrum Disorder* 40%	Yes	Yes
	Early Intervention Services None	No	No
	All Other Covered Therapies 40%	Yes	Yes
12. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired	40%	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?**
ear every five years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Note: For Covered Persons under age 18, Benefits for a replacement hearing aid will be provided if alterations to the existing hearing aid cannot adequately meet the Covered Person's needs.			
13. Home Health Care			
Limited to 28 hours per week, not to exceed 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider we identify. **Home Health Special Services Program -** Limited to 15 visits per lifetime. This does not count toward the 60 visits limit above.	40%	Yes	Yes
14. Hospice Care			
	40%	Yes	Yes
15. Hospital - Inpatient Stay			
	40%	Yes	Yes
16. Lab, X-Ray and Diagnostics - Outpatient			

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 Policy, 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?**
Lab Testing - Outpatient	$40 per service at a freestanding lab or in a Physician's office	Yes	No
	$100 per service at a Hospital-based lab	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient	40% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	40% at an outpatient Hospital-based diagnostic center	Yes	Yes
17. Major Diagnostic and Imaging - Outpatient			
	40% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	40% at an outpatient Hospital-based diagnostic center	Yes	Yes
18. Manipulative Treatment			
Limited to 20 visits per year.	$35 per visit	Yes	No
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient 40%	Yes	Yes
	Outpatient 40% for Partial Hospitalization/Intensive Outpatient Treatment/Intensive Behavioral Therapy *Office Visit* 40%	Yes Yes	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 Policy, 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?**
	Urgent Care None	No	No
20. Necessary Medical Supplies			
	40%	Yes	Yes
21. Orthotics			
	40%	Yes	Yes
22. Pharmaceutical Products - Outpatient			
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. **Note**: Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drugs* section.	40%	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 facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Inpatient* 40% *Outpatient* 40% at a freestanding center or in a Physician's office 40% at an outpatient Hospital-based center	Yes Yes Yes	Yes Yes Yes
24. Physician's Office Services - Sickness and Injury			

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 Policy, 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?**
	$5 per visit for services provided by your Primary Care Physician 40% for services provided by a Network Specialist $5 per visit for services provided by any other Network Physician	Yes Yes Yes	No Yes No
25. Pregnancy - Maternity Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* 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. Preventive Care Services			
Physician office services	None	No	No
Lab, X-ray or other preventive tests	None	No	No
Breast pumps	None	No	No
27. Prosthetic Devices			
	Arm & Leg Prosthetic Devices 20%	Yes	No
	All Other Prosthetic Devices 40%	Yes	Yes
28. Reconstructive Procedures			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
29. Rehabilitation Services - Outpatient Therapy			

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 Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy.	40%	Yes	Yes
30. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	40%	Yes	Yes
31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Skilled Nursing Facility limited to 100 days per year.	40%	Yes	Yes
32. Surgery - Outpatient			
	40%	Yes	Yes
33. Telehealth			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
34. Temporomandibular Joint Syndrome (TMJ)			
	40%	Yes	Yes
35. Therapeutic Treatments - Outpatient			
	40%	Yes	Yes
36. Transplantation Services			
Transplantation services must 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 each Covered Health Care Service category in this *Schedule of Benefits.*		

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 Policy, 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?**
Covered expenses for lodging and ground transportation will be limited to $10,000 per year.			
37. 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: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	$75 per visit	Yes	No
38. Virtual Care Services			

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 Policy, 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?**
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/exchange or the telephone number on your ID card.	*Primary Care* $5 per visit *Urgent Care* None	Yes No	No No

Allowed Amounts

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

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

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

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

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, 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 Ac*t with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

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

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

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

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

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

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

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

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

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

Provider Network

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

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

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

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

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

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

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.

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 bariatric surgery) 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.

Outpatient Prescription Drugs Section 1: Schedule of Benefits (Who Pays What)

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.

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 *Section 7: Benefits/Coverage (What is Covered)* of your *Policy*, regardless of tier placement.

Benefits for Prescription Eye Drop Refills

Benefits will be provided for refills of covered prescription eye drops when all of the conditions below are met:

- The original prescription states that additional quantities of the eye drops are needed and the refill requested does not exceed the number of additional quantities needed.
- The refill is requested by the Covered Person within the following timeframes:
  - For a 30-day supply of eye drops, the refill must be requested at least twenty-one days from the later of the date of the original prescription or the date the last refill was distributed to the Covered Person.
  - For a 60-day supply of eye drops, the refill must be requested at least forty-two days from the later of the date of the original prescription or the date the last refill was distributed to the Covered Person.
  - For a 90-day supply of eye drops, the refill must be requested at least sixty-three days from the later of the date of the original prescription or the date the last refill was distributed to the Covered Person.

Benefits will be provided for one additional bottle of covered prescription eye drops if the bottle is requested by the Covered Person or the prescribing health care provider at the time the original prescription is filled and when the original prescription states that one additional bottle of eye drops is needed by the Covered Person for use in a day care center, school, or adult day program. Benefits for the additional bottle of eye drops are limited to one bottle every 3 months.

Benefits for Tobacco Cessation Drugs

For adults who use tobacco, FDA-approved tobacco cessation drugs and/or over the counter items as required by PPACA:

- Up two 90-day treatment courses are covered at no cost each year for members over the age of 18 years old.

Benefits for Treatment of Opioid Dependence

Benefits for the treatment of opioid dependence will be provided without prior authorization for a 5-day supply for at least one FDA-approved drug for the initial fill request within a 12-month period.

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

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

How Do Supply Limits Apply?

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

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

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

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician or your pharmacist 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 your Physician or your pharmacist 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 or the pharmacist are responsible for obtaining prior authorization from us.

If prior authorization is not obtained 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 Policy in *Section 10: Claims Procedure (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/exchange or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under *Outpatient Prescription Drugs* in *Section 7: Benefits/Coverage (What is Covered)* of the Policy are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

For Covered Persons with stage four advanced metastatic cancer, step therapy requirements do not apply to covered Prescription Drug Products that have been approved by the *United States Food and Drug Administration* if the use of the approved Prescription Drug Product is consistent with:

- The *United States Food and Drug Administration*-approved indication;
- The *National Comprehensive Cancer Network Drugs and Biologics Compendium* indication for the treatment of stage four advanced metastatic cancer; or
- Peer-reviewed medical literature.

A Covered Person is not required to undergo step therapy or obtain prior authorization for HIV infection prevention drugs prescribed and dispensed by a pharmacist in accordance with state law. "HIV infection prevention drug" means preexposure prophylaxis, post-exposure prophylaxis, or other drugs approved by the *United States Food and Drug Administration* for the prevention of HIV infection.

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

Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)

When a Prescription Drug Product is not listed on the PDL, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the second highest tier. For example, if you have a 5-tier plan, then the 4th tier would be considered the second highest tier.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours.

Expedited External Review

If you are not satisfied with our determination of your exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.

What Do You Pay?

You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your Policy before Benefits for Prescription Drug Products under this Policy are available to you unless otherwise allowed under your Policy. We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the *Benefit Information* table. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

The Co-payment amount or Co-insurance percentage you pay for a Prescription Drug Product will not exceed the Usual and Customary Charge of the Prescription Drug Product.

The amount you pay for any of the following under your Policy may not be included in calculating any Out-of-Pocket Limit stated in your Policy:

- 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.

Payment Information

NOTE: When Covered Health Care Services are provided by an Indian Health Service provider, your cost share may be reduced.

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. **Special Programs**: We may have certain programs in which you may receive a reduced Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.	For Prescription Drug Products at a Retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. The Co-payment or Co-insurance you pay for a covered prescription insulin drug will not exceed $100 for a 30-day supply. You may obtain up to a 30-day supply of insulin products listed on the Prescription Drug List at a Network Pharmacy at $0 cost to you.

Schedule of Benefits Information Table

- Your Co-payment and/or Co-insurance is determined by Prescription Drug Products on the Prescription Drug List placed on Tier 1, Tier 2, Tier 3, Tier 4, Tier 5, or Tier 6.
- Prescription Drug Products supply limit:
  - Retail Network Pharmacy – 30 or 90 days
  - Mail Order Network Pharmacy – 90 days
  - Specialty and Opioid Prescription Drug Products at a Network Pharmacy – 30 days
  - Prescription contraception - up to a 12-month period based on the Covered Person's prescription.
- Ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, not 30-day supply with three refills.
- You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed or days the drug will be delivered for any Prescription Orders or Refills at any Network Pharmacy.

AMOUNTS SHOWN ARE YOUR COST RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN MET			
The amounts you are required to pay as shown below are based on the Prescription Drug Charge.			
	Retail Network Pharmacy		Mail Order Network Pharmacy
	30-Day Supply	90-Day Supply	90-Day Supply
Tier 1	None per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	None per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	None per Prescription Order or Refill. Not subject to payment of the Annual Deductible.
Tier 2	$5 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$12.50 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$12.50 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.
Tier 3	$60 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$150 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$150 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.
Tier 4	40% of the Prescription Drug Charge per Prescription Order or Refill. Subject to payment of the Annual Deductible.	40% of the Prescription Drug Charge per Prescription Order or Refill. Subject to payment of the Annual Deductible.	40% of the Prescription Drug Charge per Prescription Order or Refill. Subject to payment of the Annual Deductible.
Tier 5	40% of the Prescription Drug Charge per Prescription Order or Refill. Subject to payment of the Annual Deductible.	40% of the Prescription Drug Charge per Prescription Order or Refill. Subject to payment of the Annual Deductible.	40% of the Prescription Drug Charge per Prescription Order or Refill. Subject to payment of the Annual Deductible.
Tier 6	50% of the Prescription Drug Charge per Prescription Order or Refill.	50% of the Prescription Drug Charge per Prescription Order or Refill.	50% of the Prescription Drug Charge per Prescription Order or Refill.

	Subject to payment of the Annual Deductible.	Subject to payment of the Annual Deductible.	Subject to payment of the Annual Deductible.

Pediatric Dental Care Services Section 1: Schedule of Benefits (Who Pays What)

How do you Access Pediatric Dental Care Services?

Network Benefits

Benefits - Benefits apply when you choose to obtain Covered Dental Care Services from a Network Dental Provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service that is greater than the contracted fee.

In order for Covered Dental Care Services to be paid, you must obtain all Covered Dental Care Services directly from or through a Network Dental Provider.

You must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can check the participation status by contacting us and/or the provider. We can provide help in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call us at the number stated on your identification (ID) card to determine which providers participate in the Network.

Benefits are not available for Dental Care Services that are not provided by a Network Dental Provider.

Payment Information

Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Care Services and Benefits will not be payable.

Out-of-Pocket Limit - any amount you pay in Coinsurance for Pediatric Dental Care Services under this section applies to the Out-of-Pocket Limit stated in the *Covered Health Care Services Schedule of Benefits*.

Schedule of Benefits Information Table

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Diagnostic Services - (Not subject to payment of the Annual Deductible.)	
Evaluations (Checkup Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. Periodic oral evaluation. Limited oral evaluation - problem focused. Teledentistry - synchronous - real time encounter.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. Comprehensive oral evaluation. Comprehensive periodontal evaluation. *The following service is not subject to a frequency limit.* Detailed and extensive oral evaluation - problem focused.	
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. Complete series (including bitewings). Intraoral - complete series of radiographic images - image capture only.	None
The following services are not subject to a frequency limit. Intraoral - periapical first film. Intraoral - periapical - each additional film. Intraoral - occlusal film. Intraoral - occlusal radiographic image - image capture only. Intraoral - periapical radiographic image - image capture only.	None
Any combination of the following services is limited to 2 series of films per 12 months. Bitewings - single film. Bitewings - two films. Bitewings - four films. Vertical bitewings. Intraoral - bitewing radiographic image - image capture only.	None
Limited to 1 time per 36 months. Panoramic radiograph image. Panoramic radiographic image - image capture only. 2-D Cephalometric radiographic image - image capture only. 3-D Photographic image - image capture only.	None
The following services are limited to two images per calendar year.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Extra-oral posterior dental radiographic image - image capture only.	
The following services are not subject to a frequency limit. Cephalometric X-ray. Oral/Facial photographic images. Interpretation of diagnostic image. Diagnostic casts. 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) *The following services are limited to two times every 12 months.* Prophylaxis - adult. Prophylaxis - child.	None
Fluoride Treatments *The following services are limited to two times every 12 months.* Fluoride.	None
Sealants (Protective Coating) *The following services are* limited to once per first or second permanent molar every 36 months. Sealant - per tooth - unrestored permanent molar. Preventive resin restorations in moderate to high caries risk patient - permanent tooth.	None
Space Maintainers (Spacers) *The following services are not subject to a frequency limit.* Space maintainer - fixed, unilateral - per quadrant. Space maintainer - fixed - bilateral maxillary. Space maintainer - fixed - bilateral mandibular. Space maintainer - removable, unilateral - per quadrant. Space maintainer - removable - bilateral maxillary.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Space maintainer - removable - bilateral mandibular. Re-cement or re-bond bilateral space maintainer - maxillary. Re-cement or re-bond bilateral space maintainer - mandibular. Re-cement or re-bond unilateral space maintainer - per quadrant. Removal of fixed unilateral space maintainer - per quadrant. Removal of fixed bilateral space maintainer - maxillary. Removal of fixed bilateral space maintainer - mandibular. Distal shoe space maintainer - fixed - unilateral - per quadrant.	
Minor Restorative Services - (Not subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* Amalgams - one surface, primary or permanent. Amalgams - two surfaces, primary or permanent. Amalgams - three surfaces, primary or permanent. Amalgams - four or more surfaces, primary or permanent.	None
Composite Resin Restorations (Tooth Colored Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* Resin-based composite - one surface, anterior. Resin-based composite - two surfaces, anterior. Resin-based composite - three surfaces, anterior. Resin-based composite - four or more surfaces or involving incised angle, anterior.	None
Crowns/Inlays/Onlays - (Not subject to payment of the Annual Deductible.)	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are subject to a limit of one time every 60 months. Onlay - metallic - two surfaces. Onlay - metallic - three surfaces. Onlay - metallic - four surfaces. Crown - porcelain/ceramic substrate. Crown - porcelain fused to high noble metal. Crown - porcelain fused to predominately base metal. Crown - porcelain fused to noble metal. Crown - porcelain fused to titanium and titanium alloys. Crown - 3/4 cast high noble metal. Crown - 3/4 cast predominately base metal. Crown - 3/4 porcelain/ceramic. Crown - full cast high noble metal. Crown - full cast predominately base metal. Crown - full cast noble metal. Crown - titanium and titanium alloys. Prefabricated stainless steel crown - primary tooth. Prefabricated stainless steel crown - permanent tooth. *The following services are not subject to a frequency limit.* Inlay - metallic - one surface. Inlay - metallic - two surfaces. Inlay - metallic - three surfaces. Re-cement inlay. Re-cement crown.	None
The following service is not subject to a frequency limit. Protective restoration.	None
The following services are limited to one time per tooth every 60 months. Prefabricated porcelain crown - primary. Core buildup, including any pins.	None
The following service is limited to one time per tooth every 60 months.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Pin retention - per tooth, in addition to crown.	
The following service is not subject to a frequency limit. Prefabricated post and core in addition to crown.	None
The following services are not subject to a frequency limit. Crown repair necessitated by restorative material failure. Inlay repair. Onlay repair. Veneer repair. *The following service is limited to one time per tooth every 36 months.* Resin infiltration/smooth surface.	None
Endodontics - (Not subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. Therapeutic pulpotomy (excluding final restoration).	None
The following service is not subject to a frequency limit. Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	None
The following services are not subject to a frequency limit. Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	None
The following services are not subject to a frequency limit. Anterior root canal (excluding final restoration). Bicuspid root canal (excluding final restoration). Molar root canal (excluding final restoration). Retreatment of previous root canal therapy - anterior. Retreatment of previous root canal therapy - bicuspid.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Retreatment of previous root canal therapy - molar.	
The following services are not subject to a frequency limit. Apexification/recalcification - initial visit. Apexification/recalcification - interim medication replacement. Apexification/recalcification - final visit.	None
The following service is not subject to a frequency limit. Pulpal regeneration.	None
The following services are not subject to a frequency limit. Apicoectomy/periradicular - anterior. Apicoectomy/periradicular - bicuspid. Apicoectomy/periradicular - molar. Apicoectomy/periradicular - each additional root. Surgical repair of root resorption - anterior. Surgical repair of root resorption - premolar. Surgical repair of root resorption - molar. Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	None
The following service is not subject to a frequency limit. Root amputation - per root.	None
The following service is not subject to a frequency limit. Hemisection (including any root removal), not including root canal therapy.	None
Periodontics - (Not subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 36 months.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Gingivectomy or gingivoplasty - four or more teeth. Gingivectomy or gingivoplasty - one to three teeth. Gingivectomy or gingivoplasty - with restorative procedures, per tooth.	
The following services are limited to one every 36 months. Gingival flap procedure, four or more teeth. Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	None
The following service is not subject to a frequency limit. Clinical crown lengthening - hard tissue.	None
The following services are limited to one every 36 months. Osseous surgery. Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant. Bone replacement graft - first site in quadrant.	None
The following services are not subject to a frequency limit. Pedicle soft tissue graft procedure. Free soft tissue graft procedure.	None
The following services are not subject to a frequency limit. Subepithelial connective tissue graft procedures, per tooth. Soft tissue allograft. Free soft tissue graft - first tooth. Free soft tissue graft - additional teeth.	None
The following services are limited to one time per quadrant every 24 months. Periodontal scaling and root planing - four or more teeth per quadrant. Periodontal scaling and root planing - one to three teeth per quadrant. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following service is limited to a frequency to one per lifetime. Full mouth debridement to enable comprehensive evaluation and diagnosis.	None
The following service is limited to four times every 12 months in combination with prophylaxis. Periodontal maintenance.	None
Removable Dentures - (Not subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 60 months. Complete denture - maxillary. Complete denture - mandibular. Immediate denture - maxillary. Immediate denture - mandibular. Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular. Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.	
The following services are not subject to a frequency limit. Adjust complete denture - maxillary. Adjust complete denture - mandibular. Adjust partial denture - maxillary. Adjust partial denture - mandibular. Repair broken complete denture base. Repair broken complete denture base - mandibular. Repair broken complete denture base - maxillary. Replace missing or broken teeth - complete denture. Repair resin denture base. Repair resin partial denture base - mandibular. Repair resin partial denture base - maxillary. Repair cast framework. Repair cast partial framework - mandibular. Repair cast partial framework - maxillary. Repair or replace broken retentive/clasping materials - per tooth. Replace broken teeth - per tooth. Add tooth to existing partial denture. Add clasp to existing partial denture.	None
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. Rebase complete maxillary denture. Rebase maxillary partial denture. Rebase mandibular partial denture. Reline complete maxillary denture (direct).	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Reline complete mandibular denture (direct). Reline maxillary partial denture (direct). Reline mandibular partial denture (direct). Reline complete maxillary denture (indirect). Reline complete mandibular denture (indirect). Reline maxillary partial denture (indirect). Reline mandibular partial denture (indirect). Reline mandibular partial denture (laboratory). Add metal substructure to acrylic full denture (per arch).	
The following services are not subject to a frequency limit. Tissue conditioning (maxillary). Tissue conditioning (mandibular).	None
Bridges (Fixed partial dentures) - (Not subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. Pontic - cast high noble metal. Pontic - cast predominately base metal. Pontic - cast noble metal. Pontic - titanium and titanium alloys. Pontic - porcelain fused to high noble metal. Pontic - porcelain fused to predominately base metal. Pontic - porcelain fused to noble metal. Pontic - porcelain fused to titanium and titanium alloys. Pontic - porcelain/ceramic.	None
The following services are not subject to a frequency limit. Retainer - cast metal for resin bonded fixed prosthesis. Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	None
The following services are not subject to a frequency limit. Inlay/onlay - porcelain/ceramic. Inlay - metallic - two surfaces. Inlay - metallic - three or more surfaces.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Onlay - metallic - three surfaces. Onlay - metallic - four or more surfaces.	
The following services are limited to one time every 60 months. Retainer crown - porcelain/ceramic. Retainer crown - porcelain fused to high noble metal. Retainer crown - porcelain fused to predominately base metal. Retainer crown - porcelain fused to noble metal. Retainer crown - porcelain fused to titanium and titanium alloys. Retainer crown - 3/4 cast high noble metal. Retainer crown - 3/4 cast predominately base metal. Retainer crown - 3/4 cast noble metal. Retainer crown - 3/4 porcelain/ceramic. Retainer crown - 3/4 titanium and titanium alloys. Retainer crown - full cast high noble metal. Retainer crown - full cast predominately base metal. Retainer crown - full cast noble metal.	None
The following service is not subject to a frequency limit. Re-cement or re-bond fixed partial denture.	None
The following services are not subject to a frequency limit. Core build up for retainer, including any pins. Fixed partial denture repair necessitated by restorative material failure.	None
Oral Surgery - (Not subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. Extraction, erupted tooth or exposed root.	None
The following services are not subject to a frequency limit. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Removal of impacted tooth - soft tissue. Removal of impacted tooth - partially bony. Removal of impacted tooth - completely bony. Removal of impacted tooth - completely bony with unusual surgical complications. Surgical removal or residual tooth roots. Coronectomy - intentional partial tooth removal.	
The following service is not subject to a frequency limit. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	None
The following service is not subject to a frequency limit. Surgical access of an unerupted tooth.	None
The following services are not subject to a frequency limit. Alveoloplasty in conjunction with extractions - per quadrant. Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. Alveoloplasty not in conjunction with extractions - per quadrant. Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant.	None
The following service is not subject to a frequency limit. Removal of lateral exostosis (maxilla or mandible).	None
The following services are not subject to a frequency limit. Incision and drainage of abscess. Suture of recent small wounds up to 5 cm. Collect - apply autologous product. Bone replacement graft for ridge preservation - per site. Buccal/labial frenectomy (frenulectomy). Lingual frenectomy (frenulectomy). Excision of pericoronal gingiva.	None
Adjunctive Services - (Not subject to payment of the Annual Deductible.)	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. Palliative (Emergency) treatment of dental pain - minor procedure.	None
Covered only when clinically Necessary. Deep sedation/general anesthesia first 30 minutes. Dental sedation/general anesthesia each additional 15 minutes. Deep sedation/general anesthesia - first 15 minutes. Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. Intravenous conscious sedation/analgesia - first 30 minutes. Intravenous conscious sedation/analgesia - each additional 15 minutes. Therapeutic drug injection, by report.	None
Covered only when clinically Necessary. Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	None
The following are limited to one guard every 12 months. Occlusal guard - hard appliance, full arch. Occlusal guard - soft appliance, full arch. Occlusal guard - hard appliance, partial arch.	None
Implant Procedures - (Not subject to payment of the Annual Deductible.)	
The following services are limited to one time every 60 months. Endosteal implant. Surgical placement of interim implant body. Eposteal implant. Transosteal implant, including hardware. Implant supported complete denture. Implant supported partial denture. Connecting bar implant or abutment supported. Prefabricated abutment.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Custom abutment. Abutment supported porcelain ceramic crown. Abutment supported porcelain fused to high noble metal. Abutment supported porcelain fused to predominately base metal crown. Abutment supported porcelain fused to noble metal crown. Abutment supported cast high noble metal crown. Abutment supported cast predominately base metal crown. Abutment supported porcelain/ceramic crown. Implant supported porcelain/ceramic crown. Implant supported crown - porcelain fused to high noble alloys. Implant supported crown - high noble alloys. Abutment supported retainer for porcelain/ceramic fixed partial denture. Abutment supported retainer for porcelain fused to high noble metal fixed partial denture. Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture. Abutment supported retainer for porcelain fused to noble metal fixed partial denture. Abutment supported retainer for cast high noble metal fixed partial denture. Abutment supported retainer for predominately base metal fixed partial denture. Abutment supported retainer for cast metal fixed partial denture. Implant supported retainer for ceramic fixed partial denture. Implant supported retainer for FPD - porcelain fused to high noble alloys. Implant supported retainer for metal FPD - high noble alloys. Implant/abutment supported fixed partial denture for completely edentulous arch. Implant/abutment supported fixed partial denture for partially edentulous arch. Implant maintenance procedure.	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure. Implant supported crown - porcelain fused to predominantly base alloys. Implant supported crown - porcelain fused to noble alloys. Implant supported crown - porcelain fused to titanium and titanium alloys. Implant supported crown - predominantly base alloys. Implant supported crown - noble alloys. Implant supported crown - titanium and titanium alloys. Repair implant prosthesis. Replacement of semi - precision or precision attachment. Repair implant abutment. Remove broken implant retaining screw. Abutment supported crown - porcelain fused to titanium and titanium alloys. Implant supported retainer - porcelain fused to predominantly base alloys. Implant supported retainer for FPD - porcelain fused to noble alloys. Implant removal. Debridement peri-implant defect. Debridement and osseous peri-implant defect. Bone graft peri-implant defect. Bone graft implant replacement. Implant/abutment supported interim fixed denture for edentulous arch - mandibular. Implant/abutment supported interim fixed denture for edentulous arch - maxillary. Implant supported retainer - porcelain fused to titanium and titanium alloys. Implant supported retainer for metal FPD - predominantly base alloys. Implant supported retainer for metal FPD - noble alloys. Implant supported retainer for metal FPD - titanium and titanium alloys.	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Implant index. Semi-precision abutment - placement. Semi-precision attachment - placement. Abutment supported retainer - porcelain fused to titanium and titanium alloys.	

Pediatric Vision Care Services Section 1: Schedule of Benefits (Who Pays What)

How do you Access Pediatric Vision Care Services?

Network Benefits

Benefits - Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhc.com/exchange.

Benefits are not available for Vision Care Services that are not provided by a UnitedHealthcare Vision Network Vision Care Provider.

Payment Information

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Annual Deductible

Unless otherwise stated, Benefits for pediatric Vision Care Services provided under this section are subject to any Annual Deductible stated in the *Covered Health Care Services Schedule of Benefits.*

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this section applies to the Out-of-Pocket Limit stated in the *Covered Health Care Services Schedule of Benefits*.

Schedule of Benefits Information Table

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

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam or Refraction only in lieu of a complete exam	Once every 12 months.	None Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once every 12 months.	
• Single Vision		40% Subject to payment of the Annual Deductible.
• Bifocal		40% Subject to payment of the Annual Deductible.
• Trifocal		40% Subject to payment of the Annual Deductible.
• Lenticular		40% Subject to payment of the Annual Deductible.
Lens Extras		
• Polycarbonate lenses	Once every 12 months.	None

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
		Subject to payment of the Annual Deductible.
• Standard scratch-resistant coating	Once every 12 months.	None Subject to payment of the Annual Deductible.
Eyeglass Frames	Once every 12 months.	
• Eyeglass frames with a retail cost up to $130.		40% Subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $130 - 160.		40% Subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $160 - 200.		40% Subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $200 - 250.		40% Subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost greater than $250.		40% Subject to payment of the Annual Deductible.
Contact Lenses and Fitting & Evaluation		
• Contact Lens Fitting & Evaluation	Once every 12 months.	None Not subject to payment of the Annual Deductible.
• Covered Contact Lens Formulary	Limited to a 12 month supply.	40% Subject to payment of the Annual Deductible.
Necessary Contact Lenses	Limited to a 12 month supply.	40% Subject to payment of the Annual Deductible.
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be	Once every 24 months.	

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
limited to the amounts stated.		
• Low vision testing		None Not subject to payment of the Annual Deductible.
• Low vision therapy		25% of billed charges. Subject to payment of the Annual Deductible.

Section 2: Title Page (Cover Page)

Rocky Mountain Health Maintenance Organization, Incorporated

Individual Exchange Medical Policy

2775 Crossroads Boulevard

Grand Junction, CO, 81506

888-809-6539

Colorado

IMPORTANT NOTICE: This Policy does not provide any dental benefits to individuals age nineteen (19) or older. This Policy is being offered so the purchaser will have pediatric dental coverage as required by the *Affordable Care Act*. If you want adult dental benefits, you will need to buy a plan that has adult dental benefits. This Policy will not pay for any adult dental care, so you will have to pay the full price of any care you receive.

Section 3: Contact Us

Rocky Mountain Health Maintenance Organization, Incorporated

2775 Crossroads Boulevard

Grand Junction, CO 81506

888-809-6539

Introduction to Your Policy

This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 15: Definitions*.

When we use the words "we," "us," and "our" in this document, we are referring to Rocky Mountain Health Plans. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 15: Definitions*.

How Do You Use This Document?

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

Review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 7: Benefits/Coverage (What is Covered)* and *Section 8: Limitations/Exclusions (What is Not Covered)*. Read *Section 11: General Policy Provisions* to understand how this Policy 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 *Policy* and any summaries provided to you, this *Policy* 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 ID card. Throughout the document you will find statements that encourage you to contact us for more information.

Section 4: Table of Contents

Section 5: Eligibility

How Do You Enroll?

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Colorado Health Benefit Exchange if you enroll through the exchange, or by Rocky Mountain if you enroll off the exchange. 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 this Policy.

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

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

Who Is Eligible for Coverage?

If you enroll through the exchange, the Colorado Health Benefit Exchange determines who is eligible to enroll and who qualifies as a Dependent. If you enroll off the exchange, Rocky Mountain will determine who is eligible to enroll and who qualifies as a Dependent under the terms of this Policy.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Colorado Health Benefit Exchange for enrollments through the exchange. For off exchange enrollments, eligibility will be determined by us under the terms of this Policy and will be based on the information submitted in the application for coverage.

When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 15: Definitions*.

Eligible Persons must live within the Service Area.

Dependent

Dependent generally refers to the Policyholder'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 15: Definitions*.

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

When Do You Enroll and When Does Coverage Begin?

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

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Colorado Health Benefit Exchange or by us in accordance with state or federal law and the terms of this Policy.

Coverage begins on the date determined by the Colorado Health Benefit Exchange or by us and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Colorado Health Benefit Exchange or by us in accordance with state or federal law and the terms of this Policy.

1. An Eligible Person may enroll, or change QHPs, outside of the Open Enrollment Period if the request to enroll is made within 30 days before or 60 days after any of the following events:

- You gain a Dependent through marriage, birth, adoption, placement for adoption, placement in foster care, child support order or other administrative order, or by entering into a Civil Union or Designated Beneficiary Agreement. To enroll in a QHP as a result of a marriage, you must either provide proof to the Colorado Health Benefit Exchange of:
  - Having minimum essential coverage at least 1 or more days in the 60 days prior to the marriage;
  - Having lived in a foreign country or in a U.S. territory for 1 or more days in the 60 days prior to the marriage;
  - To be an Indian; or
  - Having lived in an area where there was not a QHP available through the exchange for 1 or more days in the 60 days prior to the marriage. If you are already enrolled, you must stay on your current QHP.
- If you enrolled for this Policy on the exchange and the Policyholder or Dependent, who was not previously a citizen, national, or lawfully present individual gains such status. If you are already enrolled, you can change to a different QHP of the same metal level.
- Your enrollment or non-enrollment in a QHP or other health benefit plan is unintentional, inadvertent, or a mistake and is the result of the mistake, misrepresentation, misconduct or inaction of a carrier, producer or an officer, employee, or agent of the Colorado Health Benefit Exchange or the *U.S. Department of Health and Human Services (HHS)* or a non-Colorado Health Benefit Exchange entity providing enrollment assistance or conducting enrollment activities. If you are already enrolled, you can change to a QHP of any metal level. For purposes of this section, misconduct means the failure to follow the standards of PPACA or other applicable federal or state laws as determined by the Colorado Health Benefit Exchange.
- You show the Colorado Health Benefit Exchange or the Colorado Division of Insurance that your QHP or other health benefit plan substantially violated a material provision of its contract with you. If you are already enrolled, you can change to a different QHP of any metal level.
- If you enrolled for this Policy on the exchange, you show the Colorado Health Benefit Exchange, per HHS guidelines, that you meet other exceptional circumstances as the exchange may provide. If you are already enrolled, you can change to a QHP of any metal level.
- If you or your Dependent enrolled for a policy on the exchange or off the exchange, and show the Colorado Health Benefit Exchange or the Colorado Division of Insurance, as applicable, that a material error related to the policy's benefits, service area, or premium influenced you or your Dependent's decision to buy the policy.
- A parent or legal guardian disenrolling a Dependent, or a Dependent becoming ineligible for CHP+ coverage.
- The Policyholder or Dependent's becoming ineligible for Medicaid coverage. If you are already enrolled, you can change to a different QHP of the same metal level.
- If you or your Dependent applied for coverage during the Open Enrollment Period or due to a triggering event, and are assessed as eligible for Medicaid or CHP+ coverage, but later determined ineligible for Medicaid or CHP+ either after the Open Enrollment Period is over or more than 60 days after the triggering event, or if you or your Dependent applied for coverage through the Colorado Medicaid or CHP+ programs during their open enrollment periods, and are determined ineligible for Medicaid or CHP+ after such open enrollments periods have ended.
- If you are: a) a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim in a household, you already are enrolled in minimum essential coverage, and you want to enroll in coverage apart from the doer of the abuse or abandonment, or b) a dependent of such a victim. If this happens, you can change to a QHP of any metal level.
- If you gain access to new QHPs as a result of a permanent move. To enroll in a QHP as a result of a permanent move, proof may be required of:
  - Having minimal essential coverage for at least 1 or more days in the 60 days prior to the move;
  - Having lived in a foreign country or in a U.S. territory for 1 or more days in the 60 days prior to the move;

- Be an Indian; or
- Having lived in an area where there was not a QHP available through the Colorado Health Benefit Exchange for 1 or more days prior to the move.

2. An Eligible Person and/or Dependent may enroll outside of the Open Enrollment Period if the request to enroll is made within 60 days before or 60 days after any of the following events, unless otherwise noted below. If any of the below events occur, you can change to a different QHP of the same metal level. An Eligible Person or Dependent:

- Lose minimum essential coverage or existing Creditable Coverage for any reason other than fraud or failure to pay a Premium. The date of the loss of coverage is the last day you would have coverage under your previous plan or coverage.
- Enrolled in any non-calendar year health insurance policy that will expire. This is even if you have the option to renew the expiring non-calendar year individual health insurance policy. The date of the loss of coverage is the date of the expiration of the non-calendar year policy.
- Lose pregnancy-related coverage described in the *Social Security Act* or lose access to health care services through coverage provided to an unborn child. The date of the loss of coverage is the last day you have pregnancy-related or unborn child coverage.
- Lose a Dependent or are no longer considered a Dependent through divorce, legal separation or death.
- The Colorado Health Benefit Exchange determines the Policyholder or Dependent to be newly eligible or newly ineligible for the federal advance premium tax credit or cost sharing reductions available through the exchange under federal law. This only applies if the Policyholder or Dependent is not currently enrolled in a silver level QHP. If you are newly ineligible, you can enroll in a QHP of any metal level.
- Lose medically needy coverage as described in the *Social Security Act* only once per calendar year. The date of the loss of coverage is the last day you would have medically needy coverage.
- Who are enrolled in an ineligible employer-sponsored plan are determined newly eligible for advance payments of the premium tax credit. This is based in part on a finding that you are ineligible for qualifying coverage in an eligible employer-sponsored plan, including as a result of your employer discontinuing or changing available coverage within the next 60 days, as long as you are allowed to terminate existing coverage.
- Become newly eligible to enroll in a QHP through the exchange because of release from incarceration.
- Were not eligible for federal premium tax credit only because of a household income below 100% of the Federal Poverty Level. This only applies if, during the same period, you or your Dependents were not also eligible for Medicaid due to living in a non-Medicaid expansion state. In such case, if you or your Dependents has a change in household income or moves to a different state, either of which results in you or your Dependents becoming newly eligible for advance payments of the federal premium tax credit.

3. An Eligible Person and/or Dependents may enroll, or change QHPs, outside of the Open Enrollment Period if the request is made within 60 days after:

- An involuntary loss of coverage for you and your Dependents at the end of the term of a short term limited duration health insurance policy you or your Dependents bought. This only applies if there is no ability to purchase another short-term policy due to the short-term policy carrier ending its sales of all short-term policies in Colorado on or after April 1, 2019. You must give us proof of the termination of the short-term policy with an end date on or after April 1, 2019.

Special Enrollment Effective Dates

If an Eligible Person timely requests to enroll, the effective date of coverage will be:

- No later than the first day of the month following plan selection after the marriage, Civil Union, or loss of Creditable Coverage.
- The date of the birth, adoption, or placement in foster care, or if you request, the first day of the month following plan selection after the birth, adoption or placement in foster care.
- The date a court order for gaining or becoming a Dependent is effective, or if your request, the first day of the month following plan selection after the court order or if you request, as set forth below for all other events.
- For all other events:

- An appropriate date based on the circumstances, if such flexibility is allowed under state or federal law;
- The date of the event if coverage is requested prior to the event;
- The first day of the following month if coverage is purchased between the 1st and the 15th day of the month; or
- The first day of the second following month if coverage is purchased after the 15th day of the month.

The Colorado Health Benefit Exchange may permit the Policyholder to choose other effective dates.

Special Enrollment Verification

Rocky Mountain has a process to verify eligibility for special enrollment periods. We use this process to confirm that you or your Dependent is eligible to enroll. We may ask for documents to confirm this. Information on our process and on documents that we may require you to provide is on our website at www.myuhc.com/exchange or upon request.

Native Americans/Alaskan Natives

If the Policyholder or Dependent is an Indian, then he or she may enroll in a QHP or change from one QHP to another one time per month.

Adding New Dependents on the Exchange

If this Policy was obtained through the exchange, the Policyholder must notify Colorado Health Benefit Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow Colorado Health Benefit Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by Colorado Health Benefit Exchange.

NOTE. Subject to a determination of Colorado Health Benefit Exchange, an eligible child born to you or your spouse will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for loss due to Injury and Sickness, including loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Adding New Dependents off the Exchange

If this Policy was obtained off the exchange, the Policyholder must notify Rocky Mountain of a new Dependent to be added to this Policy. Additional Premium may also be required, and it will be calculated from the date coverage is effective.

Dependent Eligibility

Your Dependents become eligible for insurance on the later of following:

- The date you became insured under this Policy.
- The first day of the first full calendar month after the date of becoming your Dependent.

Effective Date for Initial Dependents:

The effective date for your initial Dependents, if any, is shown on the face page of the Policy. Only Dependents included in the application for insurance will be covered on your effective date.

Adding a Newborn Child:

A Dependent child born to you or your spouse will be covered from the time of birth until the 31st day after birth, unless you or your spouse advises us not to add the newborn child. Additional Premium may be required to continue coverage beyond the 31st day following the birth. The required Premium will be calculated from the date of birth. Coverage of the child will terminate on the 31st day following birth, unless we have received both written notice of the child's birth and the required premium within 90 days of the date of birth.

Adding an Adopted Child:

A Dependent child legally placed for adoption with you or your spouse will be covered from the date of placement until the 31st day after placement, unless the placement is disrupted prior to legal adoption and the child is removed from your or your spouse's custody. Additional Premium may be required to continue coverage beyond the 31st day following the placement of the child. The required Premium will be calculated from the date of placement for adoption. Coverage of the child will terminate on the 31st day following placement, unless we have received both written notice of your or your spouse's intent to adopt the child and the required premium within 90 days of the date of placement.

As used in this provision, "placement" means the earlier of the following:

- The date that you or your spouse assume physical custody of the child for the purpose of adoption.
- The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.

Adding a Foster Child

A Dependent child legally placed in foster care with you or your spouse must be enrolled within 60 days after the placement in foster care. The effective date of coverage will be the date of placement in foster care. The required Premium will be calculated from the date of placement in foster care.

Adding New Dependents Due to Marriage or Civil Union

A person who becomes a Dependent due to marriage or Civil Union must be enrolled within 60 days after the date of marriage or Civil Union. Coverage will begin on the date of the marriage or recording of the Civil Union if we receive the request to enroll 30 days before that date. If not, coverage begins the first day of the month after the date of the marriage or Civil Union. The required Premium will change on the effective of coverage.

Adding a Designated Beneficiary

A person who becomes a Designated Beneficiary must be enrolled within 60 days after the Designated Beneficiary Agreement is recorded. If we receive the request to enroll 30 days before the Designated Beneficiary Agreement is recorded, coverage will begin on the date the Designated Beneficiary Agreement is recorded. The required Premium will change on the effective date of coverage.

Section 6: How to Access Your Services and Obtain Approval of Benefits

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.

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.

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.

Obtain Prior Authorization

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

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.

Access Plan

We have prepared and maintain a Network access plan that describes how we monitor the Network of providers to ensure that you have access to Network providers. The access plan also has information on complaint procedures, quality programs and Benefits for *Emergency Health Care Services - Outpatient*. The Network access plan is maintained at our offices. See *Section 3: Contact Us* for our address and telephone number.

Section 7: Benefits/Coverage (What is Covered)

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 15: Definitions*).
- You receive Covered Health Care Services while this Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 12: Termination/Nonrenewal/Continuation* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements.

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 this Policy.

Please note that coverage will not be denied for Covered Health Care Services specifically provided for in this section when the services are required as the result of self-harm or suicide attempt or completion.

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."

1. Acupuncture

Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the practitioner/provider. It is recommended that acupuncture be part of a coordinated plan of care approved by the member's practitioner/provider. These Benefits cover acupuncture and acupressure treatment.

2. Ambulance Services

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

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

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network Inpatient Rehabilitation Facility or 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:

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

3. Bariatric Surgery

The plan covers surgical treatment of morbid obesity provided all of the following are true:

- You have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a minimum Body Mass Index (BMI) of 40, or > 35 with at least 1 co-morbid condition present.
- You must enroll in the Optum Bariatric Resource Services (BRS) program, a surgical weight loss solution for those individual(s) who qualify clinically for Morbid Obesity Surgery.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You have a 3-month Physician supervised diet documented within the last 2 years.
- One surgery per lifetime unless complications.
- Excess skin removal post bariatric surgery is not covered, unless Medically Necessary.

4. Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.

- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- 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.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under this Policy.

5. Dental Anesthesia

General anesthesia and associated Hospital and facility charges provided to an Enrolled Dependent child when, in the opinion of the treating dentist, at least one of the following criteria is met:

- The child has a physical, mental, or medically compromising condition.
- The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy.
- The child is extremely uncooperative, unmanageable, or uncommunicative and has dental needs deemed sufficiently important that the dental care cannot be deferred.

- The child has sustained extensive orofacial and dental trauma.

6. Diabetes Services

Diabetes Self-Management and Training and Education Services

"Diabetes self-management training and educational services" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications, when the instruction is provided in accordance with a program in compliance with the National Standards of Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a health care professional and when provided by a certified, registered or licensed health care professional. Diabetes self-management training and educational services does not include programs with the primary purpose of weight reduction. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care, and diabetic specific foot orthotics, orthopedic shoes, inserts, modifications, and footwear when Medically Necessary for the treatment of complications related to diabetes.

Diabetic Self-Management Supplies

Benefits for blood glucose control and testing including insulin syringes with needles, blood glucose and urine test strips, lancets and lancet devices, ketone test strips, single measurement glucose monitors, including those for the legally blind, and certain insulin pumps, are described under the *Outpatient Prescription Drugs section.* Continuous glucose monitors are excluded as described under the *Outpatient Prescription Drugs* section. Continuous glucose monitors and certain insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).

7. Durable Medical Equipment (DME)

Benefits are provided for DME. 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 is limited to:

- Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Rocky Mountain.
- Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Rocky Mountain.
- Infant apnea monitors are provided.

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

Benefits are available for fitting, repairs and replacement, except as described in *Section 8: Limitations/Exclusions (What is Not Covered).*

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 Policy.

8. Emergency Health Care Services - Outpatient

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

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

In the case of an Emergency, you may call the 911 emergency telephone access number or its local equivalent. We provide Benefits for Allowed Amounts resulting from the use of emergency telephone access numbers in the case of an Emergency.

9. Enteral Nutrition

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

For the purpose of this Benefit, “enteral formulas” include prescription medical foods for the treatment of inherited enzymatic disorders. “Inherited enzymatic disorders” means a disorder caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions which includes, without limitation, the following diagnosed conditions:

- Phenylketonuria.
- Maternal phenylketonuria.
- Maple syrup urine disease.
- Tyrosinemia.
- Homocystinuria.
- Histidinemia.
- Urea cycle disorders.
- Hyperlysinemia.
- Glutaric acidemias.
- Methylmalonic acidemia.
- Propionic acidemia.
- Immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins.
- Severe food protein induced enterocolitis syndrome.
- Eosinophilic disorders as evidenced by the results of a biopsy.
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

10. Gender Affirming Health Services

Benefits for gender affirming health services for the treatment of gender dysphoria provided by or under the direction of a Physician.

Coverage is available for medical, behavioral or pharmacological treatment that is Medically Necessary gender affirming care for gender dysphoria. In compliance with *Section 5.E.3* of *Colorado Regulation 4-2-62,* Rocky Mountain does not deny, exclude or otherwise limit Covered Health Care Services for Benefits based on an associated diagnosis of gender dysphoria, or otherwise discriminate against Covered Persons based upon their sexual orientation or gender identity.

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

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician include the following services. For services requiring prior authorization, the Physician must submit an authorization request with appropriate clinical documentation to Rocky Mountain. A decision will be rendered by Rocky Mountain based on evaluation of medical necessity, clinical documentation, and covered Benefits.

- Preventive health care services are provided as described under *Preventive Care Services*.
- Psychotherapy is provided as described under *Mental Health Care and Substance-Related and Addictive Disorders Services*.
- Cross-sex hormone therapy administered by a Physician.
- Cross-sex hormone therapy and puberty suppressing medications dispensed at a pharmacy are provided as described under the *Outpatient Prescription Drugs* Benefit.

- Laboratory testing to monitor the safety of hormone therapy is provided as described under *Lab, X-Ray and Diagnostic - Outpatient*.
- Medically Necessary gender affirming care for gender dysphoria includes the following procedures:
  - Genital surgical procedures, including:
    - Penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, prostatectomy, urethroplasty, vagina/perineum reconstruction, and dilator medical equipment.
    - Hysterectomy, ovariectomy/oophorectomy, salpingectomy, metoidioplasty, phalloplasty, vaginectomy, vulvectomy, scrotoplasty, urethroplasty, trachelectomy, penis/perineum reconstruction, implantation of erection and/or testicular prosthesis.
  - Non-genital surgical procedures, including:
    - Blepharoplasty (eye and lid modification).
    - Face/forehead and/or neck tightening.
    - Facial feminization surgery, including bone remodeling.
    - Genioplasty (chin width reduction).
    - Rhytidectomy (cheek, chin, and neck).
    - Cheek, chin, nose implants.
    - Lip lift/augmentation.
    - Mandibular angle augmentation/creation/reduction (jaw).
    - Orbital recontouring.
    - Liposuction.
    - Lipofilling.
    - Rhinoplasty (nose reshaping).
    - Laser or electrolysis hair removal.
    - Voice modification surgery.
    - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
    - Gluteal augmentation (implants/lipofilling).
    - Pectoral implants.
    - Nipple reconstruction following mastectomy.
  - Breast/chest surgical procedures, including:
    - Breast augmentation, reduction, construction.
    - Augmentation mammoplasty.
    - Implants/lipofilling.
    - Subcutaneous mastectomy (for creation of male chest).
    - Simple/total mastectomy.
    - Partial mastectomy.
    - Modified radical mastectomy.
    - Radical mastectomy.
  - Voice lessons and voice therapy.

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. Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care

Service category, such as *Lab, X-Ray and Diagnostics – Outpatient, Physician's Office Services – Sickness and Injury, Preventive Care Services, Surgery – Outpatient, Pharmaceutical Products – Outpatient,* and in the *Outpatient Prescription Drugs* section.

The following cosmetic procedures are excluded from this policy:

- Abdominoplasty.
- Brow lift.
- Calf implants.
- Injection of fillers and neurotoxins.
- Hair transplantation or reconstruction.
- Lip reduction.
- Mastopexy.
- Skin resurfacing.

11. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, 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*.

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

Habilitative Benefits for Covered Persons with Autism Spectrum Disorder include outpatient physical, occupational and speech therapy when prescribed by a Network Physician as Medically Necessary.

Early childhood intervention services for Enrolled Dependent children from birth to age 3 who have significant delays in development or have a diagnosed physical or mental condition that has high probability of resulting in significant delays in development are covered up to the maximum amount permitted by state law.

Physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for children from age 3 to age 6 are covered without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

12. Hearing Aids

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

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid 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.

Cochlear implants are not hearing aids. Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this Policy. 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.

13. 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 a home health aide, home health therapist, or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Sickness or Injury requiring the Home Health 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.

Home Health Special Services Program

If you have been diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible for the Home Health Special Services Program ("Program"). This Program allows you to receive up to 15 home health care visits per lifetime. These visits are covered under the Program until you elect hospice care coverage.

The difference between this Program and regular visiting nurse visits is that:

- You may or may not be homebound or have skilled care needs.
- You may only require spiritual or emotional care.

Services available through this Program are provided by professionals with specific training in end-of-life issues.

14. 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.

15. 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).
- Room and board in a private room and inpatient private duty nursing when Medically Necessary.
- Physician services for radiologists, anesthesiologists, pathologists and Emergent ER Services Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

16. 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.

Benefits include:

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

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*.

17. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

18. Manipulative Treatment

Benefits are provided for Manipulative Treatment (adjustment) including diagnostic and treatment services. Benefits include therapy to treat problems of the bones, joints, and back.

Benefits are limited as described in the Schedule of Benefits.

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

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

Coverage will be provided for Medically Necessary Covered Health Care Services for which Benefits are otherwise described in this Policy, regardless of whether the services are received voluntarily on your part or court ordered as the result of contact with the criminal justice or juvenile justice system.

Benefits include the following levels of care:

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

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

Services include the following:

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

    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 Policy.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

20. Necessary Medical Supplies

Medical Supplies that are used with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., oxygen tubing or mask, batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

21. Orthotics

Orthotic devices means rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.

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

Benefits are available for fitting, repairs and replacement, except as described in *Section 8: Limitations/Exclusions (What is Not Covered)*.

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 Policy. Benefits for medication normally available by a prescription or order or refill are provided as described under *Outpatient Prescription Drugs.*

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

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product, unless the provider or its intermediary agrees in writing to accept reimbursement, including copayment, at the same rate as a Designated Dispensing Entity.

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

We may have certain programs in which you may receive an enhanced 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/exchange or the telephone number on your ID card.

For Covered Persons with stage four advanced metastatic cancer, step therapy requirements do not apply to covered Pharmaceutical Products or Prescription Drug Products that have been approved by the *United States Food and Drug Administration* if the use of the approved Pharmaceutical Product or Prescription Drug Product is consistent with:

- The *United States Food and Drug Administration*-approved indication;
- The *National Comprehensive Cancer Network Drugs and Biologics Compendium* indication for the treatment of stage four advanced metastatic cancer; or
- Peer-reviewed medical literature.

A Covered Person is not required to undergo step therapy or obtain prior authorization for HIV infection prevention drugs prescribed and dispensed by a pharmacist in accordance with state law. "HIV infection prevention drug" means preexposure prophylaxis, post-exposure prophylaxis, or other drugs approved by the *United States Food and Drug Administration* for the prevention of HIV infection.

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 when both of the following are true:

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

Covered Health Care Services include:

- Genetic Counseling.
- Allergy testing and injections.
- Medical nutrition therapy provided by a licensed dietician or nutritionist, working in coordination with a Physician, to treat a chronic illness or condition.
- Remote Physiologic Monitoring services.
- Diagnosis and treatment of the underlying causes of infertility, and for artificial insemination. Depending on where a service is received, Benefits will be provided under the corresponding Benefit category in this Policy.

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

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

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

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 of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery. If 48 hours following delivery falls after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.
- 96 hours for the mother and newborn child following a cesarean section delivery. If 96 hours following delivery falls after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.

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

Benefits are provided for well-baby care in the Hospital, including a newborn pediatric visit and newborn hearing screening.

26. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force (USPSTF).* Services include annual mental health wellness screenings in conjunction with physical exams.
- 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*.
- Contraception coverage which includes the following:
  - We cover all eighteen (18) forms of emergency and preventative contraception approved by the *FDA* at no-cost to the consumer and included in the *Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines*. These include tubal ligation, various intrauterine devices (IUDs), implants, shots, oral contraceptives (sometimes known as "the pill"), patches, vaginal rings, diaphragms, sponges, cervical caps, female condoms, spermicide, and emergency contraceptives (sometimes known as "Plan B"). The no-cost coverage also includes contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., office visits, management, evaluation, associated laboratory testing, as well as changes to and removal or discontinuation of the contraceptive method).
  - We cover twelve (12) months of a prescription contraceptive at one time.

  While We may utilize certain medical management techniques to prioritize coverage of one medication or item in the same category, it does not use the following techniques, as they create unreasonable delay: Denial of coverage for all or particular brand name contraceptives, fail-first or step therapy requirements, and age limitations on coverage.

  If you require a different type of contraception, We will cover, without cost to the enrollee, any necessary contraceptive service or item, and the Company will defer to your provider's determination. We have an exceptions process to request a different type of contraception that is easily accessible, transparent, sufficiently expedient, and not unduly burdensome on You or your provider. More information about the exceptions process can be found here: https://www.uhcprovider.com/en/resource-library/drug-lists-pharmacy/individual-exchange-plans-prior-authorization-and-exceptions.html.
- Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc/exchange or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost-effective pump. We will determine the following:
  - Which pump is the most cost-effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.
- Prostate cancer screening which consists, at a minimum, of a prostate-specific antigen (PSA) blood test and a digital rectal exam, according to the following guidelines:
  - One screening per year for Covered Persons age 50 and over.
  - One screening per year for Covered Persons age 40 and over who are in high risk categories, as determined by a Physician.
- Annual breast cancer screening using the appropriate noninvasive imaging modality or combination of modalities recognized by the *American College of Radiology*, the *National Comprehensive Cancer Network*, or their successor entities, for all individuals possessing at least one risk factor for breast cancer including:
  - A family history of breast cancer;
  - Being forty years of age or older; or
  - An increased lifetime risk of breast cancer determined by a risk factor model such as tyrer-cuzick, BRCAPRO, or GAIL or by other clinically appropriate risk assessment models.

- Coverage for human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) coverage includes the following:
    - We will cover federal *Food and Drug Administration (FDA)*-approved HIV PrEP medication prescriptions without Co-payment or cost-sharing if your provider or pharmacist determines that you are indicated for PrEP.
    - Coverage will include baseline and monitoring services consistent with *USPSTF* recommendations without Co-payment or cost-sharing.

  Prior authorization for HIV PrEP medication from a non-pharmacist provider will be processed on an urgent basis within 24 hours of receipt.
- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps in accordance with "A" or "B" recommendations of the *USPSTF*.

  In addition to Covered Persons eligible for coverage in accordance with "A" or "B" recommendations of the USPSTF, coverage will also be provided for Covered Persons who are at high risk for colorectal cancer, including Covered Persons who have:
    - A family medical history of colorectal cancer;
    - A prior occurrence of cancer or precursor neoplastic polyps;
    - A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or
    - Other predisposing factors as determined by a participating provider.
- Authorized, approved, or recommended vaccines for COVID-19, including all associated costs of administration.

27. Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras.
- Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn Members are covered when Medically Necessary and prescribed by a Network Physician.

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

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 fitting, repairs and replacement, except as described in *Section 8: Limitations/Exclusions (What is Not Covered),* under *Devices, Appliances and Prosthetics.*

28. Reconstructive Procedures

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

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

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

Cosmetic Procedures are excluded from coverage. Cosmetic Procedures do not include Medically Necessary gender affirming care for which Benefits are provided as described under *Gender Affirming Health Services* or reconstructive procedures for treatment of a Congenital Anomaly of a newborn child. 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 and treatment of complications such as lymphedemas during all stages of a mastectomy, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Cleft Lip and Cleft Palate Treatment

The following services when provided by or under the direction of a Physician in connection with the treatment of cleft lip and/or cleft palate:

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy for which Benefits are provided as described under *Habilitative Services*.
- Prosthetic devices such as obturators, speech appliances and feeding appliances for which Benefits are provided as described under *Prosthetic Devices*.
- Otolaryngological services for which Benefits are provided as described under *Hospital – Inpatient Stay, Surgery – Outpatient, and Physician's Office Services – Sickness and Injury*.
- Surgical management for which Benefits are provided as described under *Hospital – Inpatient Stay, Surgery – Outpatient, and Physician's Office Services – Sickness and Injury*.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services for which Benefits are provided as described under *Hearing Aids*.
- Prosthodontic services for which Benefits are provided as described under *Pediatric Dental Care Services*.

If a dental insurance policy is in effect at the time of the birth, or is purchased after the birth of a Covered Person with cleft lip or cleft palate or both, Benefits will be provided through the dental insurance policy for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. Except as provided above, no Benefits will be provided through this Policy for any dental care needed as a result of the cleft lip or cleft palate or both.

29. 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*.

Benefits for pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.

- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

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

Physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for children from age 3 to age 6 are covered without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

30. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Benefits are available for:

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

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

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

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

Benefits for Inpatient Rehabilitation Facility services 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.

Benefits are not available for services in a Long-term Acute Care Facility (LTAC).

32. Surgery - Outpatient

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

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

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

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*.)
- Voluntary male sterilization and associated anesthesia.

Tissue transplants and cornea transplants when ordered by a Physician. Benefits are available for tissue and cornea transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service. You can call us at the telephone number on your ID card for information regarding Benefits for tissue and cornea transplant services.

33. Telehealth

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

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

34. Temporomandibular Joint Syndrome (TMJ)

Benefits include charges for Covered Health Care Services to diagnose and treat temporomandibular joint and craniomandibular disorders when treatment is needed for:

- Accidental damage.
- Trauma.
- Congenital Anomaly.
- Developmental defect.
- Pathology.

Benefits for non-surgical treatment of temporomandibular joint and craniomandibular disorders include intra-oral splints that stabilize or reposition the jaw joint.

Benefits do not include charges that are incurred for any service related to fixed or removable appliances that involve movement or repositioning of the teeth, occlusal (bite) adjustments, treatment of malocclusion, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures, dental implants).

35. Therapeutic Treatments - Outpatient

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

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

- Radiation oncology.

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

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

Benefits include:

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

36. Transplantation Services

Organ 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.

Examples of transplants for which Benefits are available include:

- Bone marrow.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under this 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.

37. 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*.

38. Virtual Care Services

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

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

Benefits are available for Primary care, which is general and non-emergency care, delivered through live audio with video or audio only technology from a Primary Care Physician.

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 medical needs.

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

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

Outpatient Prescription Drugs

This section of the Policy provides Network Benefits for Prescription Drug Products.

NOTE: The Coordination of Benefits provision in the Policy in Section *11: General Policy Provisions* applies to Prescription Drug Products covered through this section. 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 this Policy.

Coverage Policies and Guidelines

Our Individual and Family Plan Pharmacy Management Committee (IPMC) makes tier placement changes on our behalf. The IPMC places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic information. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen up to monthly. These changes may happen without prior notice to you. In the event that a Prescription Drug Product that you are currently taking moves to a higher tier or is removed from the PDL, we will notify you no less than 30 days prior to the change. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card for the most up-to-date tier placement.

When considering a Prescription Drug Product for tier placement, the IPMC 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: Tier status for a Prescription Drug Product may be determined by accessing your Benefits for Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. The tier to which a Prescription Drug Product is assigned may change as detailed in the Policy.

Prescription Drug Products that are considered to be PPACA Zero Cost Share Preventive Care Medications will be provided at $0 cost share for Covered Persons.

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 Policy in *Section 10: Claims Procedure (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:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

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 choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may not have coverage.

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.

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-Rocky Mountain entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

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

Are Discounts and Incentives Available to You?

From time to time, we may make access available to discounts or incentive programs. Incentive programs may be available only to targeted populations and may include other incentives.

These discount and incentive programs are not insurance and are not an insurance benefit or promise in the Policy. Your access to these programs is provided by us separately or independently from the Policy, and may be discontinued at any time. There is no additional charge for you to access these discount and incentive programs.

These programs may be offered or administered directly by us or through a third party vendor. If we receive any funds from a third party vendor in conjunction with making the discount or incentive programs available to you, we will use those funds to offset our costs of providing you access to the programs.

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 and/or any applicable deductible or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drugs Section 1: Schedule of Benefits (Who Pays What)* for applicable Co-payments, Co-insurance and/or any applicable deductible requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

Please see *Section 15: Definitions* for a full description of Specialty Prescription Drug Products.

The *Outpatient Prescription Drugs Section 1: Schedule of Benefits (Who Pays What)* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

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

The *Outpatient Prescription Drugs Section 1: Schedule of Benefits (Who Pays What)* will tell you how retail Network Pharmacy supply limits apply.

Depending upon your plan design, this section may offer limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com/exchange.

Prescription Drug Products from a Mail Order Network Pharmacy

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

The *Outpatient Prescription Drugs Section 1: Schedule of Benefits (Who Pays What)* will tell you how mail order Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com/exchange 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.

PPACA and Preventive Care Medications

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), certain preventive medications are available to you at no cost, both prescription and over-the-counter (OTC). These are called PPACA Zero Cost Share Preventive Care Medications. These preventive medications are covered at no cost to you, without charging a Co-payment, Co-insurance, or deductible when:

- Prescribed by a Physician;
- Your age and/or condition is appropriate for the recommended preventive medication;
- The medication is filled at a Network Pharmacy.

Contact us at www.myuhc.com/exchange or call the number on your ID card to find out if a medication is a PPACA Zero Cost Share Preventive Care Medication.

If your health care provider determines you need a medication that is not on the PPACA Zero Cost Share Preventive Care Medication list, they can let us know your medication is Medically Necessary and provide information about your diagnosis and medication history. If you are using your medication for an appropriate condition and it is approved, it will be covered at no cost to you. If you are using it to treat another medical condition, a cost share may apply.

List of Zero Cost Share Medications

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

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

Pediatric Dental Care Services

This section of the Policy provides Benefits for Covered Dental Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end last day of the month the Covered Person reaches the age of 19.

What Are Covered Dental Care Services?

You are eligible for Benefits for Covered Dental Care Services listed in this section if such Dental Care Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Care Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this section.

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be given a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Benefits for Pediatric Dental Care Services

Benefits are provided for the Dental Care Services stated in this section when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be given a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 8: Limitations/Exclusions (What is Not Covered)*.

Benefits

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

Pediatric Vision Care Services

This section of the Policy provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

Benefits for Pediatric Vision Care Services

What Are the Benefit Descriptions?

Benefits

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

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-insurance stated under each Vision Care Service in the *Pediatric Vision Care Services Section 1: Schedule of Benefits (Who Pays What)*.

Routine Vision Exam

A routine vision exam of the eyes and according to the standards of care in your area, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Section 8: Limitations/Exclusions (What is Not Covered)

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 7: Benefits/Coverage (What is Covered)* or through a *Rider* to this *Policy*.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 7: Benefits/Coverage (What is Covered)*, 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. Aromatherapy.
2. Hypnotism.
3. Massage therapy.
4. Rolfing.
5. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
6. Art therapy, music therapy, dance therapy, animal assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 7: Benefits/Coverage (What is Covered)*.

B. Dental

1. Dental care (which includes dental X-rays and other imaging studies, supplies and appliances and all related expenses, including hospitalizations and anesthesia). This exclusion does not apply to pediatric dental services, treatment of cleft lip or cleft palate, or dental hospitalization and general anesthesia for children for which Benefits are provided as described under *Pediatric Dental Care Services*, *Reconstructive Procedures*, and *Dental Anesthesia* in *Section 7: Benefits/Coverage (What is Covered).*

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

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of 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 does not apply to pediatric dental services, treatment of cleft lip or cleft palate, or dental hospitalization and general anesthesia for children for which Benefits are provided as described under Pe*diatric Dental Care Services*, *Reconstructive Procedures*, and *Dental Anesthesia* in *Section 7: Benefits/Coverage (What is Covered).*
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to pediatric dental services, treatment of cleft lip or cleft palate, or dental hospitalization and general anesthesia for children for which Benefits are provided as described under *Pediatric Dental Care Services*, *Reconstructive Procedures*, and *Dental Anesthesia* in *Section 7: Benefits/Coverage (What is Covered).*
4. Dental braces (orthodontics). This exclusion does not apply to treatment of cleft lip or cleft palate for which Benefits are provided as described under *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered)*.
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to pediatric dental services or treatment of cleft lip or cleft palate for which Benefits are provided as described under *Pediatric Dental Care Services* or *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*
6. Dental services following accidental injury to teeth.

B.1 Pediatric Dental

Except as may be specifically provided as described under *Pediatric Dental Care Services* in *Section 7: Benefits/Coverage (What is Covered)*, Benefits are not provided for the following:

1. Dental Care Services received from an out-of-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in *Pediatric Dental Care Services Section 1: Schedule of Benefits (Who Pays What)*.
3. Dental Care Services that are not Necessary.
4. Hospitalization or other facility charges. This exclusion does not apply to hospitalization or facility charges for which Benefits are provided as described under *Hospital – Inpatient Stay* or *Dental Anesthesia* in *Section 7: Benefits/Coverage (What is Covered).*
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. This exclusion does not apply to reconstructive surgery or treatment of cleft lip or cleft palate for which Benefits are provided as described under *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*
7. Any Dental Procedure not directly related with dental disease.
8. Any Dental Procedure not performed in a dental setting. This exclusion does not apply to Dental Procedures for which Benefits are provided as described under *Telehealth* in *Section 7: Benefits/Coverage (What is Covered).*
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. 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.

10. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit. This exclusion does not apply to drugs/medications for which Benefits are provided as described under *Outpatient Prescription Drugs* in *Section 7: Benefits/Coverage (What is Covered).*
11. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue. This exclusion does not apply to treatment for which Benefits are provided as described under *Physician Fees for Surgical and Medical Services* in *Section 7: Benefits/Coverage (What is Covered).*
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. This exclusion does not apply to treatment for which Benefits are provided as described under *Physician Fees for Surgical and Medical Services* or *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*
13. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (*TMJ)*, either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. This exclusion does not apply to TMJ-related services for which Benefits are provided as described under *Temporomandibular Joint Services (TMJ)* in *Section 7: Benefits/Coverage (What is Covered).*
15. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice, telephone consultations and sales tax.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this section of the Policy.
17. Dental Care Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Care Services for dental conditions arising prior to the date individual coverage under the Policy ends.
18. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
19. Foreign Services are not covered outside of the United States.
20. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. This exclusion does not apply to prosthodontic restoration procedures for which Benefits are provided as described under *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (*VDO*).
22. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia. This exclusion does not apply to acupuncture treatment for which Benefits are provided as described under *Acupuncture* in *Section 7: Benefits/Coverage (What is Covered).*
25. Dental braces (orthodontics).
26. Services that exceed the frequency limitations as identified in this section.

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 *Diabetes Services* in *Section 7: Benefits/Coverage (What is Covered).*

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.
   - All other DME except as described under *Durable Medical Equipment (DME), Orthotics,* and *Prosthetic Devices* in *Section 7: Benefits/Coverage (What is Covered).*
4. Devices and computers to help in communication and speech.
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. Powered wheelchairs.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. See *Outpatient Prescription Drugs* in *Section 7: Benefits/Coverage (What is Covered)* for prescription drug products covered under the pharmacy benefit.
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.
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.
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 of condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 7: Benefits/Coverage (What is Covered).*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to monthly.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to monthly.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to monthly.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to monthly.

11. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

D.1 Outpatient Prescription Drugs

Exclusions from coverage listed in the Policy *also* apply to this section. 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/exchange 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.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay. This exclusion does not apply to drugs for which Benefits are provided as described under *Hospital – Inpatient Stay* in Section *7: Benefits/Coverage (What is Covered)*.
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 does not include Prescription Drug Products that have been approved by the *U.S. Food and Drug Administration (FDA)* for use in the treatment of cancer but have not been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
    - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
    - The treatment is for a Covered Health Care Service.
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 Policy. This includes certain forms of vaccines/immunizations. This exclusion does not apply to certain 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 Policy. 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.
13. Certain unit dose packaging or repackagers of Prescription Drug Products.
14. Medications used for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.

16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

17. Prescription Drug Products when prescribed to treat infertility.

18. Prescription Drug Products not placed on a tier of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.

19. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 5.)

20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to prescribed over-the-counter aids and/or drugs used for tobacco cessation or over-the-counter medications that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* when prescribed by a Network provider for which Benefits are provided as described under *Preventive Care Services* in *Section 7: Benefits/Coverage (What is Covered)*.

21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our IPMC.

22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.

24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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.

    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) and

- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
- Such determinations may be made up to monthly. 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.
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.
32. Drugs to treat sexual dysfunction and/or impotency.

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 7: Benefits/Coverage (What is Covered).*

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. Foot orthotics, orthopedic shoes, inserts, modifications, and footwear except as described under *Diabetes Services* in *Section 7: Benefits/Coverage (What is Covered)*.
5. Arch supports.

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Items routinely found in the home.
   - Ostomy Supplies.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME) and Prosthetic Devices* in *Section 7: Benefits/Coverage (What is Covered).*

- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 7: Benefits/Coverage (What is Covered)*.
- Nitrate urine test strips for home use for pediatric members.

2. Tubings except when used with DME as described under *Durable Medical Equipment (DME)* in *Section 7: Benefits/Coverage (What is Covered).*
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. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 8: Limitations/Exclusions (What is Not Covered)*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 7: Benefits/Coverage (What is Covered).*

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Transitional Living including recovery residences.
8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
9. Residential care for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
10. Services provided in unlicensed, and, or non-accredited program. Treatment or services that are non-professionally directed.
11. Marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

I. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement under *Preventive Care Services* in *Section 7: Benefits/Coverage (What is Covered)* or nutritional counseling as described under *Physician's Office Services – Sickness and Injury* in *Section 7: Benefits/Coverage (What is Covered)*. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is a part of treatment.

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

2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 7: Benefits/Coverage (What is Covered).*
3. Nutritional or dietary supplements, except as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist, or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.
4. Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as listed in the benefit plan.

J. Personal Care, Comfort or Convenience

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

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 15: Definitions*. Examples include:
   - Membership costs and fees for health clubs and gyms. This exclusion does not apply to incentives provided as described under the heading *Are Incentives Available to You?* in *Section 11: General Policy Provisions*.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered)*.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered)*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. This exclusion does not apply to Medically Necessary panniculectomy.
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 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. This exclusion does not apply to services and treatment for which Benefits are provided as described under *Rehabilitation Services – Outpatient Therapy, Manipulative Treatment, Habilitative Services,* and *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly. This exclusion does not apply to speech therapy for which Benefits are provided as described under *Rehabilitation Services – Outpatient Therapy, Manipulative Treatment, Habilitative Services,* and *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*

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. The following services for the diagnosis and treatment of Temporomandibular Joint Syndrome (TMJ): surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
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.
10. 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.
11. Breast reduction and augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*
12. Helicobacter pylori *(H. pylori)* serologic testing.
13. Intracellular micronutrient testing.
14. Bariatric - weight loss surgery not received at a Designated Provider.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or a 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.

N. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services performed for the diagnosis and treatment of any underlying cause of infertility, or to artificial insemination services as described under *Physician's Office Services – Sickness and Injury* in *Section 7: Benefits/Coverage (What is Covered).*
2. The following services related to a Gestational Carrier or Surrogate:

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

- Delivery and post-natal care.

  The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.
7. Costs to treat sexual dysfunction and/or impotency.
8. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). This exclusion does not apply to therapeutic abortion recommended by a doctor and performed to save the life of the mother, or as a result of incest or rape.

O. Services Provided under another Plan

1. Health care services for which 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. This exclusion does not apply if your employer is not required by law to purchase or provide, through other arrangements, workers' compensation insurance for you.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

P. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* and/or *Surgery – Outpatient Services* in *Section 7: Benefits/Coverage (What is Covered)*.
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 this Policy.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider.

Q. Travel

1. Health care services provided in a foreign country.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 7: Benefits/Coverage (What is Covered).*

R. Types of Care

1. Custodial Care or maintenance care.
2. Domiciliary care.
3. Private Duty Nursing and one-on-one Private Duty Nursing. This exclusion does not apply to private duty nursing for which Benefits are provided as described under *Hospital – Inpatient Stay* in *Section 7: Benefits/Coverage (What is Covered).*
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 7: Benefits/Coverage (What is Covered)*.
5. Rest cures.
6. Services of personal care aides.
7. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).
8. Benefits are not available for services in a Long-term Acute Care Facility (LTAC).

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to contact lenses or scleral shells that are used to therapeutically treat an injury or disease (such as corneal abrasion, keratoconus or severe dry eye). This exclusion does not apply to pediatric vision care services for which Benefits are provided as described under *Pediatric Vision Care Services* in *Section 7*: *Benefits/Coverage (What is Covered).*
2. Routine vision exams, including refractive exams to determine the need for vision correction. This exclusion does not apply to pediatric vision care services for which Benefits are provided as described under *Pediatric Vision Care Services* in *Section 7: Benefits/Coverage (What is Covered).*
3. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Over-the-counter hearing aids.
7. Cochlear implants and batteries for cochlear implants.

S.1 Pediatric Vision

Except as may be specifically provided in *Section 7: Benefits/Coverage (What is Covered)* under the heading *Benefits for Pediatric Vision Care Services*, Benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-UnitedHealthcare Vision Network Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in this section under the heading *Benefits for Pediatric Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.
8. Orthoptics or vision therapy training and any associated supplemental testing.
9. Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK).
10. Contact lenses if an eyeglass frame and eyeglass lenses are received in the same calendar year.
11. Eyeglass frame and eyeglass lenses if contact lenses are received in the same calendar year.

12. Services or treatments that are already excluded in *Section 8: Limitations/Exclusions (What is Not Covered)* of the Policy.

T. 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 Policy under *Section 7: Benefits/Coverage (What is Covered)* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *Policy* under *Section 8: Limitations/Exclusions (What is Not Covered)*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under this *Policy* when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption. This exclusion does not apply to treatment for Injuries resulting from a Covered Person's casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing, or snowboarding.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary, including Medically Necessary Mental Health Care Services and Substance-Related and Addictive Disorders Services regardless of whether the services are voluntary or court-ordered as a result of contact with the criminal justice or juvenile justice system.
   - 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 7: Benefits/Coverage (What is Covered).*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under this 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 this 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 this Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term storage:
   - Long term storage services are not a Covered Health Care Service.
   - This includes, but is not limited to, long term storage (cryopreservation) of tissue, blood, blood products, sperm, eggs, and any other body or body parts. For example, if a member is entering the military, etc., we will not cover any long-term storage of the above.
   - Storage services related to infertility treatment usually only require short term storage which is generally covered as part of the retrieval and implantation charges for the infertility treatment.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

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

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

12. Proprietary Laboratory Analysis drug testing are not a covered service (such as U codes).
13. Blood or tissue typing for paternity testing are not a covered service.
14. Specimen Provenance testing are not a covered service.
15. Services or supplies for teaching, vocational, or self-training purposes, except as listed in the benefit plan.
16. Telephone consultations (except telehealth) or for failure to keep a scheduled appointment.
17. Stand-by availability of a medical practitioner when no treatment is rendered.
18. Services or supplies that are provided prior to the effective date or after the termination date of this Policy.

Section 9: Member Payment Responsibility

Enrollment and Required Premiums

Benefits are available to you if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 5: Eligibility*. To be enrolled and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with the requirements of this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or a Dependent as those terms are defined in *Section 15: Definitions*.
- You must pay Premium as required.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the *Public Health Service Act.*
- Indian tribes, tribal organizations or urban Indian organizations.
- Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which your coverage becomes effective.

Upon prior written notice, we may impose an administrative fee for credit card payments. This does not obligate us to accept credit card payments. We will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

Misstatement of Age or Tobacco Use

If your age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify Colorado Health Benefit Exchange and Rocky Mountain of your new residence. Your Premium will be based on your new residence beginning on the date determined by Colorado Health Benefit Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 12: Termination/Nonrenewal/Continuation*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Care Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate

with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under *section 36B of title 26*, as provided for by the *Patient Protection and Affordable Care Act (PPACA),* you will have a three-month grace period during which you may pay your Premium and keep your coverage in force. We will pay for Covered Health Care Services during the first month of the grace period. You are responsible for paying the grace period Premium. Prior to the last day of the three-month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the first month of the grace period until all Premiums are paid for the full three-month grace period.

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

This 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.

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*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 8: Limitations/Exclusions (What is Not Covered)* to become familiar with this Policy's exclusions.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, as a result of an Emergency or we refer you to an out-of-Network provider you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 10: Claims Procedure (How to File a Claim)*.

Use Your Prior Health Care Coverage

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

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

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.

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.

Section 10: Claims Procedure (How to File a Claim)

How Are Covered Health Care Services from Network Providers Paid?

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

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

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

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

When you receive Covered Health Care Services from an out-of-Network provider and assign Benefits to that provider as permitted by applicable law, the provider is responsible for requesting payment from us.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under Required Information.

Required Information

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

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

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

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

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Claims for Low Vision Care Services

When obtaining low Vision Care Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities as

outlined under *Payment of Claims* below apply to Vision Care Services except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Care Services

To file a claim for reimbursement for low Vision Care Services, you must provide all of the following information:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Payment of Claims

Time for Payment of Claim

Benefits will be paid after we receive all of the required information listed above within:

- 30 days for claims sent electronically.
- 45 days for claims sent by other means.

Assignment of Benefits

We will reimburse an out-of-Network hospital or health care provider directly for Benefits due under this Policy if you have assigned those Benefits to the provider. Your assignment of Benefits must be in writing. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

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

You may revoke the assignment by sending written notice to us. We will send a copy of the revocation to the provider. The revocation will be effective when it has been received by both us and the provider. You do not need the provider's approval to revoke the assignment.

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

Notice of Prompt Payment of Claims

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30-day period if additional information is needed to process the claim, and may request a one- time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with 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 in accordance with 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.

Absent fraud, all claims will be paid, denied or settled within 90 calendar days after we receive the claim.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical services. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, you will receive 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 in accordance with 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 services, 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; or
- 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 contact us by calling the telephone number on your ID card before requesting a formal appeal. If our 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 us by phone. If you first informally contact us by phone and later wish to request a formal appeal in writing, you should call us again 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 *Section 13: Appeals and Complaints* below and call the telephone number on your ID card immediately.

Section 11: General Policy Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to this Policy and how it may affect you. We administer this Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the 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 Policy.
- 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?

We have agreements in place that govern the relationship between us and Network providers, some of which are affiliated providers. Network providers enter into an agreement 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.

What Is Your Relationship with Providers?

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.

Determine Benefits

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 will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, 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 this 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 7: Benefits/Coverage (What is Covered)* and in the *Schedule of Benefits*, unless the service is excluded in *Section 8: Limitations/Exclusions (What is Not Covered)*. 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 this Policy.

Pay Network Providers

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

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

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 10: Claims Procedure (How to File a Claim)*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

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. Your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your *Schedule of Benefits*.

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-Rocky Mountain 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. We will notify you of the opportunity to participate in available programs and of any criteria for eligibility. Contact us at www.myuhc.com/exchange or the telephone number on your ID card if you have any questions.

As determined by us, incentives may include, but are not limited to, the following:

- A gym access or digital fitness class program.
- Gift card incentives valued at a maximum of $500 for completing certain activities throughout the year, such as having a wellness visit with your Primary Care Physician or taking other plan communication-related actions (e.g., signing up for text messages or paperless communications).

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

We have the sole and exclusive authority to do all of the following:

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer this 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 this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder'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 this Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this 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 this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

We have the right to subrogation and reimbursement. References to “you” or “your” in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

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

Subrogation Example:

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

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Policy as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

  - You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

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

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment

facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by the applicable statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the policyholder, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

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

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under this 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 this Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

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

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

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until proof of loss has been filed with us and the expiration of the time frame for payment has expired. Please refer to *Section 10: Claims Procedure (How to File a Claim)* for a description of the time frames on the filing and payment of claims. If you want to bring a legal action against us you must do so within three years of the date proof of loss had been filed with us and the expiration of the time frame for payment has expired or you lose any rights to bring such an action against us.

What Is the Entire Policy?

This Policy, the *Schedule of Benefits*, the Policyholder's *Application* and any Riders and/or Amendments, make up the entire Policy.

Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 12: Termination/Nonrenewal/Continuation

General Information about When Coverage Ends

As permitted by law, we may end this Policy and/or all similar policies for the reasons explained in this Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date except as described below under *Extended Coverage If You Are Hospitalized.*

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

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

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal or discontinue coverage if any of the following occur:

- Nonpayment or failure to timely pay the required Premium.
- We elect to discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation of a material fact made by you or with your knowledge in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.
- There is no longer any Covered Person that lives or resides in the Service Area.
- Your eligibility would otherwise be prohibited under applicable law.

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 this Policy ends. That date will be one of the following:

  - The date determined by the Colorado Health Benefit Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be a Policyholder or an Enrolled Dependent, as determined by the Colorado Health Benefit Exchange. Please refer to *Section 15: Definitions* for definitions of the terms “Eligible Person,” “Policyholder,” "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the Colorado Health Benefit Exchange rules if we receive notice from the Colorado Health Benefit Exchange instructing us to end your coverage.

Your coverage ends on the date determined by the Colorado Health Benefit Exchange rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

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

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

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

- **You Accept Reimbursement for Premium**

- You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:
  - *Ryan White HIV/AIDS Program* under *title XXVI of the Public Health Service Act.*
  - Indian tribes, tribal organizations or urban Indian organizations.
  - Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Coverage for a Disabled Dependent Child

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

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Policyholder 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 this 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 If You Are Hospitalized

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage would otherwise terminate, coverage will be extended until the date your Inpatient Stay ends. This extension of coverage does not apply if termination occurs due to nonpayment of Premium or fraud. This extended coverage applies only to an Inpatient Stay.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Colorado Health Benefit Exchange.

Section 13: Appeals and Complaints

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

What if You Have a Question?

Our Customer Service Representatives are trained to answer your questions about your health benefit plan. You may call or write to us. Call the telephone number shown on your ID card.

You may call during local business hours, Monday through Friday, with questions regarding:

- Your coverage and Benefit levels, including Co-insurance and Co-payment amounts.
- Specific claims or services you have received.
- Doctors or Hospitals in the Network.
- Referral processes or authorizations.
- Provider directories.

You may also complete a Member Services Request Form from myuhc.com and mail to the address included in the instructions.

What if You Have a Complaint?

A complaint is an expression of dissatisfaction.

You may write to us to file a complaint about quality of service and quality of care that you received. Call the telephone number shown on your ID card. Representatives are available to take your call during local business hours, Monday through Friday.

You may write a letter or complete a Member Services Request Form from myuhc.com. To send your complaint to us, our address is:

UnitedHealthcare Appeals & Grievances

PO Box 6111

Mail Stop CA-0197

Cypress, CA 90630

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

If someone other than yourself is submitting the complaint on your behalf, you must authorize the representative in writing.

How Do You Appeal a Decision?

An appeal is a request from you to change a previous claim or benefit decision. There are two types of appeals:

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal. Your appeal request must be submitted to us within 180 calendar days after you receive the denial of a pre-service request for Benefits or the claim denial. If the deadline for filing an appeal request ends on a weekend or holiday, the deadline shall be extended to the next business day.

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.

If someone other than yourself is submitting the complaint on your behalf, you must authorize the representative in writing.

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 by a Physician 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. By submitting an appeal, 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 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 prior to the due date of the response to the adverse benefit determination.

Appeals Determinations

For internal review of a non-urgent appeal, you choose between the written appeal review process or if an internal review hearing will be held.

Written Internal Review

If you choose to have a written internal review:

- Your appeal will be reviewed and the decision made by a qualified individual who was not involved in the initial decision. You may review your appeal file as part of the first level appeal. You will have the chance to give us written comments, documents, records, and other evidence to consider.
- If your appeal is about one of the items listed below, a Physician will decide the outcome:
  - Medical necessity of a treatment or service;
  - If a treatment is experimental or investigational;
  - If a treatment or service is not provided in the appropriate setting or at the appropriate level of care; or
  - There is a reasonable medical basis that an exclusion does not apply to the treatment or service you requested. If you claim that an exclusion does not apply, you must give us evidence from a medical professional. The evidence must support a reasonable medical basis for your claim.

Internal Review Hearing

If you choose to have an internal review hearing:

- We will notify you of the date of the hearing at least 20 calendar days before it is scheduled. If you ask that we delay the hearing, we will not unreasonably deny your request.
- You and your attorney, advocates, health care professionals, and other witnesses may attend the internal review hearing in person, by phone, or by using other technology if it is available and not unduly costly for us to use.
- At the internal review hearing, you and the Plan will have the chance to:
  - Be assisted or represented by an appointed representative of your choice including an attorney (at your own expense), other advocate or healthcare professional. If you decide to have an attorney present at the internal review hearing, then you must let us know that at least 7 days prior to that meeting.
  - Give testimony and materials to the review committee. (A copy of the materials must be given to each party at least 5 calendar days in advance. If new information arises after the deadline, this material may be presented at the hearing if feasible); and

- Have an audio or visual recording made by us. (If a recording is made, you may have a copy. If you appeal this decision through external review, a copy of the recording will be included in the material we provide to the independent external review entity unless you specifically request that it not be included.)

At the conclusion of the internal appeal process of a written appeal or internal review meeting, you will be provided written or electronic notification of the decision on your appeal as follows:

Appeal Type	Response Time from Receipt of Request
Pre-service request for Benefit appeals	30 calendar days
Post-service claim appeals	60 calendar days

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

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

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours upon receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we notify you of our decision by phone, written confirmation of the decision will be provided to you within 3 calendar days of the date we notified you of that decision by phone.

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

External Review Program

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

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

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

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

There is no minimum dollar amount for a claim to be eligible for an external review.

The external review program is not available if our coverage determination is based on a Benefit exclusion or defined Benefit limit unless you present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.

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

An external review request should include all of the following:

- A completed external review request form as specified by the *Office of the Commissioner of Insurance*.
- A signed consent form authorizing us to disclose your protected health information, including medical records, that is pertinent to the external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided or considered during the internal appeal process.
- For an expedited external review request, a Physician's certification that the Covered Person has a medical condition for which application of the time period for completion of the internal urgent appeal process or the standard external review process would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function, or for Covered Persons with a disability, would create an imminent and substantial limitation of their existing ability to live independently.
- For an external review request involving a service that is Experimental or Investigational, certification from the treating Physician that the recommended or requested health care service or treatment will be less effective if not begun immediately, and that:
  - Standard health care services or treatments have not improved the Covered Person's condition or are not medically appropriate for the Covered Person; or
  - There is no standard health care service or treatment available that is covered under the Policy and is more beneficial to the Covered Person than the recommended or requested health care service or treatment, and that the Physician is a board-certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Covered Person's condition.

  The Physician must also certify that scientifically valid studies support the health care service or treatment subject to the denial is likely to be more beneficial to the Covered Person than any available standard health care services or treatments.

If your request qualifies for an external review, our denial decision will be reviewed by an independent external review entity selected by the *Office of the Commissioner of Insurance.* We will pay the costs of the external review.

Standard External Review

Your request for an external review must be submitted to us in writing within four months of the date you received notice of our adverse determination following the completion or exhaustion of the internal appeal process.

1. Upon receipt of your request for an external review, we will deliver a copy of the request to the *Office of the Commissioner of Insurance* within 2 business days. If we deny your eligibility for external review, we will notify you, your designated representative, and the *Office of the Commissioner of Insurance* in writing with the specific reasons for the denial and information about appealing that determination to the *Office of the Commissioner of Insurance.*

   If we, before the expiration of the 2 business day deadline for sending notification to the *Office of the Commissioner of Insurance*, reverse our adverse determination based on new or additional information you submitted with your external review request, we will notify you within 1 business day of this reversal electronically, by facsimile, or by telephone followed by a written confirmation.
2. If your external review request is eligible for review, the *Office of the Commissioner of Insurance* will assign an independent external review entity and will notify us of the name and address of the entity within 2 business days of receipt of the external review request.
3. Within 1 business day of receipt of the *Office of the Commissioner of Insurance's* notice of assignment to an independent external review entity, we will notify you and your designated representative electronically, by facsimile, or by telephone followed by a written confirmation, of the name and address of the independent external review entity.
4. Within 5 business days of the date you receive notice of assignment to an independent external review entity, you or your designated representative may submit any additional information in writing to the independent external review entity that you want the entity to consider in its review.

5. The independent external review entity will conduct its review and will provide written notice of its decision to you and your designated representative, to us, and to the *Office of the Commissioner of Insurance* within 45 calendar days after receipt of the independent external review request.

6. Upon receipt of notice from the independent external review entity that our denial decision is overturned, we will approve coverage of the Covered Health Care Service that was the subject of the review:

   - Within 1 business day for concurrent and prospective reviews of pre-service requests for Benefits.
   - Within 5 business days for retrospective reviews of post-service claims.

   We will provide written notice of the approval to you and your designated representative within one business day of our approval of coverage. Coverage will be provided in accordance with the terms and conditions of the Policy.

Expedited External Review

You may file a request for an expedited external review at the same time as you file an internal urgent appeal of a prospective or concurrent service denial of Benefits if the Covered Person has a medical condition for which application of the time period for completion of the internal urgent appeal process or the standard external review process would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function, or for Covered Persons with a disability, would create an imminent and substantial limitation of their existing ability to live independently.

An expedited external review request must include a Physician's certification that the Covered Person's medical condition meets the above criteria.

An expedited external review will not be provided for post-service claim denials.

1. Within 1 business day of receipt of your request for an expedited external review, we will notify and send a copy of the request to the *Office of the Commissioner of Insurance* who will select an independent external review entity. If we deny your eligibility for independent external review, we will notify you, your designated representative, and the *Office of the Commissioner of Insurance* in writing with the specific reasons for the denial and information about appealing that determination to the *Office of the Commissioner of Insurance.*

2. If your request is eligible for review, the *Office of the Commissioner of Insurance* will assign an independent external review entity and will notify us of the name and address of the entity within 1 business day of receipt of the expedited external review request.

3. Within 1 business day of receipt of the *Office of the Commissioner of Insurance's* notice of assignment to an independent external review entity, we will notify you and your designated representative electronically, by facsimile, or by telephone followed by a written confirmation, of the name and address of the independent external review entity.

4. Upon receipt of notice of assignment to an independent external review entity, you or your designated representative may submit any additional information in writing to the independent external review entity that you want the entity to consider in its review.

5. The independent external review entity will conduct its review and will provide notice of its decision to you and your designated representative, to us, and to the *Office of the Commissioner of Insurance* within 72 hours after receipt of the expedited independent external review request. If notice of the independent external review entity's decision is not in writing, the independent external review entity will provide written confirmation of its decision within 48 hours after the date of providing that notice.

6. Immediately upon receipt of notice from the independent external review entity that our denial decision is overturned, we will approve coverage of the Covered Health Care Service that was the subject of the review and will provide written notice of the approval to you and your designated representative. Coverage will be provided in accordance with the terms and conditions of the Policy.

Binding Nature of the External Review Decision

The external review decision is final and binding unless either you or the Plan appeal the decision by timely submitting the decision to arbitration.

You or your designated representative may not file a subsequent request for an external review involving the same determination for which the Covered Person has already received an external review decision.

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

Section 14: Information on Policy and Rate Changes

What Is the Policy?

This Policy is a legal document between Rocky Mountain Health Maintenance Organization, Incorporated and you and describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's *Application* and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's *Application*.
- Riders.
- Amendments.

Can This Policy Change?

We may, from time to time, change this Policy by attaching legal documents called *Riders* and/or *Amendments* that may change certain provisions of this Policy. Changes to the Policy must be sent in writing so when this happens we will send you a new Policy, *Rider* or *Amendment*.

Amendments to this Policy

To the extent permitted by law, we have the right to change, interpret, withdraw or add Benefits or end this Policy.

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

No other change may be made to this 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 this Policy are effective upon renewal, except as otherwise permitted by law.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy, except that your coverage may end for events as described in *Section 12: Termination/Nonrenewal/Continuation*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.

This Policy will renew on January 1 of each calendar year. On January 1st, we may make modifications in coverage if such modifications are made on a uniform basis for all individuals with the same product. In addition, we may make modifications at any time if the modification is directly related to a State or Federal requirement and the modification is made within a reasonable time period after the State or Federal requirement is imposed or modified.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

Nothing in this section requires us to renew or continue coverage for which your continued eligibility would otherwise be prohibited under applicable law.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end this *Policy*, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in Colorado. This Policy is governed by Colorado law.

Section 15: Definitions

Air Ambulance - medical transport by helicopter or airplane.

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

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

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

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Care Services with that provider.

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

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

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

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

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

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

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

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities; includes the following neurobiological disorders: Autistic Disorder; Asperger's Disorder, and Atypical Autism as a diagnosis within Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS), as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, at the time of the diagnosis.

Bariatric Surgery - procedures that are performed to treat comorbid conditions associated with morbid obesity.

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

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.

Chemotherapy - charges incurred for the treatment of disease by chemical or biological antineoplastic agents or related supportive care regimens administered orally, intravenously or by injection. The chemical or biological antineoplastic agents or related supportive care regimens may be administered during a doctor's visit, home health care visit, or at an outpatient facility.

Children's Basic Health Plan or CHP+ - means the health insurance plan designed by the *Colorado Department of Health Care Policy and Financing*.

Civil Union - means a relationship established by two eligible persons in accordance with Colorado law for the purpose of entitling them to receive the benefits and protections and be subject to the responsibilities of spouses. A Civil Union will be legally recognized if:

- The two parties to the Civil Union satisfy all of the following criteria:
  - Both parties are adults, regardless of the gender of either party;
  - Neither party is a party to another Civil Union;
  - Neither party is married to another person;
  - The parties are not related to each other as an ancestor, descendant, brother, sister, uncle, aunt, niece, or nephew, whether the relationship is by the half or the whole blood.
  - Neither party is under 18 years of age or 18 years of age or older and under guardianship, unless the party under guardianship has the written consent of his or her guardian.
- The Civil Union is certified and registered with a county clerk and recorder in the State of Colorado.

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. Cosmetic Procedures do not include Medically Necessary gender affirming care for which Benefits are provided as described under *Gender Affirming Health Services* or reconstructive procedures for which Benefits are provided under *Reconstructive Procedures* in *Section 7: Benefits/Coverage (What is Covered).*

Covered Contact Lens Formulary - a selection of available contact lenses that may be obtained from a UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

Covered Dental Care Service - a Dental Care Service or Dental Procedure for which Benefits are provided under this Policy.

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 Policy under *Section 7: Benefits/Coverage (What is Covered)* and in the *Schedule of Benefits*.
- Not excluded in this Policy under *Section 8: Limitations/Exclusions (What is Not Covered)*.

Covered Person - the Policyholder or a Dependent, but this term applies only while the person is enrolled under this Policy. We use "you" and "your" in this Policy 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 - quantitative test to identify specific medications, illicit substances and metabolites with numerical results reporting the specific quantities of a substance.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide Dental Care Services, perform dental surgery or provide anesthetics for dental surgery.

Dental Care Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependent - the Policyholder's legal spouse, common law spouse, or a child of the Policyholder or the Policyholder's spouse. All references to the spouse of the Policyholder shall include a Partner in a Civil Union and a Domestic Partner. A Dependent also includes a Designated Beneficiary. The term "child" includes:

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

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 12: Termination/Nonrenewal/Continuation* under *Coverage for a Disabled Dependent Child.*

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

Designated Beneficiary - means a person who has entered into a Designated Beneficiary Agreement.

Designated Beneficiary Agreement - means an agreement that is entered into by two people for the purpose of designating each person as the beneficiary of the other person and for the purpose of ensuring that each person has certain rights and financial protections based upon the designation. The right to be designated as a dependent in a health insurance policy must be granted under the Designated Beneficiary Agreement.

A Designated Beneficiary Agreement will be legally recognized if:

- The parties to the Designated Beneficiary Agreement satisfy all of the following criteria:
  - Both are at least 18 years of age;
  - Both are competent to enter into a contract;
  - Neither party is married to another person;
  - Neither party is a party to a Civil Union;
  - Neither party is a party to another Designated Beneficiary Agreement;
  - Both parties enter into the Designated Beneficiary Agreement without force, fraud or duress, and

- The agreement is in substantial compliance with the statutory form that is considered the standard form for the Designated Beneficiary Agreement.

- A Designated Beneficiary Agreement is legally sufficient if:
  - The wording of the Designated Beneficiary Agreement complies substantially with the statutory form considered the standard form for the Designated Beneficiary Agreement;
  - The Designated Beneficiary Agreement is properly completed and signed;
  - The Designated Beneficiary Agreement is acknowledged; and
  - The Designated Beneficiary Agreement is recorded with the county clerk and recorded in the county in which one of the parties resides. The Designated Beneficiary Agreement will be effective as of the date and time as received for recording by the county clerk and recorder.

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

Designated 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 may include Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Designated Provider - a provider and/or facility that:

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

A Designated Provider may or may not be located within your 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/exchange 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 same sex with whom the Policyholder has a Domestic Partnership.

Domestic Partnership - a relationship between a Policyholder and one other person of the 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 - a person who meets the eligibility requirements determined by the Colorado Health Benefit Exchange and Rocky Mountain in accordance with state or federal law. An Eligible Person must live within the Service Area.

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

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

Emergency Health Care Services - with respect to an Emergency:

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

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

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

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

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

  e) Any other conditions as specified by the Secretary.

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

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

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
   - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;

- *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
- *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.

2. Subject to review and approval by any 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 7: Benefits/Coverage (What is Covered)*.
- Prescription Drug Products that have been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services;* and
  - The treatment is for a Covered Health Care Service.
- 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 7: Benefits/Coverage (What is Covered)*: and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

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

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

Functional or Physical Impairment - a Functional or Physical or Physiological Impairment which causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas:

- physical and motor tasks;
- independent movement;
- performing basic life functions.

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.

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.

Habilitative Services - Skilled Care services that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services covered under the Policy. Parity in this context means of like type and substantially equivalent in scope, amount and duration. 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.

Hearing Aid(s) - Hearing Aids are sound-amplifying devices designed to aid people who have a hearing impairment. Most Hearing Aids share several similar electronic components, and technology used for amplification may be analog or digital. (Semi-implantable electromagnetic Hearing Aids and bone-anchored Hearing Aids are classified by the *U.S. Food and Drug Administration (FDA)* as Hearing Aids. Some non-wearable hearing devices are described as hearing devices or hearing systems. Because their function is to bring sound more effectively into the ear of a person with hearing loss, for the purposes of this Policy, they are Hearing Aids).

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

Home Health Care Services - 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.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Injury or Sickness requiring the Home Health Care.

Hospice Care - an integrated, structured, multi-disciplinary program of palliative care for covered members facing the last six months of life due to a Terminal Illness.

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

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

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

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

Independent 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.

Indian – means any person who is a member of an Indian Tribe (includes Alaskan Natives).

Indian Tribe – means any Indian tribe, band, nation, pueblo or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the *Alaska Native Claims Settlement Act (85 Stat. 688)*, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual and Family Plan Pharmacy Management Committee (IPMC) - the committee that we designate for placing Prescription Drug Products into specific tiers.

Infusion Therapy - means treatment by placing therapeutic agents into the vein and parenteral administration of medications and nutrients.

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List (PDL) that are available at zero cost share (no cost to you). You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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.

Maintenance Program - A program with the goals to maintain the functional status or to prevent decline in function.

Manipulative Treatment (adjustment) - a form of care provided by any licensed provider acting within the scope of his or her license or certification under applicable state law for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

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

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

- In accordance with *Generally Accepted Standards of Medical Practice*.

- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, 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/exchange 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 the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

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

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

Necessary - Dental Care Services and supplies which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.

- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Care Service as defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Necessary Medical Supplies - medical supplies that are used in the home with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

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

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

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Contact us at www.myuhc.com/exchange or the telephone number on your ID card for additional information on the Network Area.

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

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

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

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.

A Network Pharmacy may be a:

- Retail Network Pharmacy.
- Specialty Network Pharmacy.
- Mail Order Network Pharmacy.

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

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

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 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.

Partner in a Civil Union – means a person who has established a Civil Union certified and registered with a county clerk and recorder in the State of Colorado.

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, anesthesiologist, acupuncturist, 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 that includes all of the following:

- This Policy.
- *Schedule of Benefits*.
- Policyholder *Application*.
- Riders.
- Amendments.

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

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

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 or 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*.

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/exchange or the telephone number on your ID card.

Pregnancy - includes all of the following:

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

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

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 (PDL) - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may

find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips;
  - certain insulin pumps;
  - lancets and lancet devices; and
  - glucose meters, including those for the legally blind, excluding continuous glucose monitors.

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

Presumptive Drug Test - qualitative test to determine the presence or absence of drugs or a drug class with results indicating a negative or positive result.

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

Private Duty Nursing - A provision of continuous Skilled Care from Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) in an individual's residence by a Home Health Agency, under the direction of the patient's Physician.

Provider - A licensed participating provider who is contracted to provide medical services to Covered Persons (as defined within the provider contract). The provider may be a Hospital, pharmacy, other facility or a Physician or health care professional who has contractually accepted the terms and conditions as set forth.

Qualified Health Plan (QHP) - means a health plan that is certified by and offered through the Colorado Health Benefit Exchange.

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from Colorado Health Benefit Exchange.

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

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

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

1) An *All Payer Model Agreement* if adopted,

2) State law, or

3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

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

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

Reconstructive Surgery - 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. Microtia repair is considered a reconstructive procedure.

Rehabilitation - health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

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 professional who has examined the patient and with whom the patient has an established, documented and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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

- Provides a program of treatment under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Medication provision/assistance.
  - Counseling.
  - Referral and orientation to specialized community resources.

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

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

Secretary - as that term is applied in the *No Surprises Act* of the C*onsolidated 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 where we act as a Qualified Health Plan Issuer as 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.

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.

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

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

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

Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. This does not include a facility primarily for rest, the aged, treatment of substance-related and addictive disorders services, or for care of behavioral health disorders.

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

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Sub-Acute Facility - means a facility that provides intermediate care on short-term or long-term basis.

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

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

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using *HIPAA*-compliant telecommunications technology, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Covered Person's health care. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Temporomandibular Joint Syndrome (TMJ) - Temporomandibular joint and muscle disorders are a collective group of conditions and symptoms characterized by pain and dysfunction to the temporomandibular joint and/or surrounding muscles that control jaw movement. Symptoms often include pain or tenderness to the temporomandibular joint, ear, neck, back, or shoulder pain, limited jaw mobility, or audible sounds with jaw movement.

Terminal Illness - in the context of hospice means a life expectancy, certified by two Physicians, of six months or less.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

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.

UnitedHealthcare Vision Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

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

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

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

Please note:

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

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person’s life. Urgent Care is usually delivered in a walk-in setting and without an appointment. Urgent Care facilities are a location, distinct from a hospital Emergency Department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

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

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement or pricing agreed to by the pharmacy and any third party. This fee includes any applicable dispensing fee and sales tax.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in *Section 7: Benefits/Coverage (What is Covered)* under the heading *Benefits for Pediatric Vision Care Services.*

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (remote interpreting service or on-site appearance)
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters (remote or on-site)
  - Information written in other languages

If you believe that RMHP has 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:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call the toll-free number on your health plan ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m., ET.

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

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

Multi-Language Insert

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

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付 費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ngtulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث العربية ، فهناك خدمات مساعدة لغوية مجانية متاحة. اتصل بالرقم المجاني على غلاف هذا الدليل.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti liv sa a.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語(Japanese) を話される場合、無料の言語支援サービスをご利用いただけ ます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر به فارسی صحبت می کنید ، خدمات کمک به زبان رایگان در دسترس است. با شماره تلفن رایگان روی جلد این راهنما تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो नि: शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। इस गाइड के कवर पर टोल-फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍: េបើសិនអ្នកនិយាយភាសាែខរ (Khmer) េសវាជំនួយភាសាេដាយឥតគិតៃថ្ល គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទេទៅេលខសមាជិកឥតគេចញៃថ្ល ជានក់េនៅខាងមុខនក្ូនេសៀវេភៅេនះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.