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UnitedHealthcare Insurance Company of the River Valley

Certificate of Coverage, Riders, Amendments, and Notices

for

VEREEN'S STORES INC

Group Number: G/GA9R6368IM **Health Plan:** AV - FX **Prescription Code:** 295A
Effective Date: December 1, 2018

Offered and Underwritten by
UnitedHealthcare Insurance Company of the River Valley

Welcome

Welcome to UnitedHealthcare Insurance Company of the River Valley . The following Certificate of Coverage of Coverage, with its attachments and amendments, explains your healthplan benefits. information carefully and keep it for future reference.

When your coverage became effective, you should have received your ID cards, which lists your coverage codes and any dependents covered under your plan. If there are any changes in your family status or address, or if you obtain other health benefit coverage, please notify your Personnel Office.

If you need a list of participating providers, or if you have any questions, please call Customer Service at the telephone number on your ID card.

Thank you for joining UnitedHealthcare Insurance Company of the River Valley .

THIS CONTRACT
PROVIDES FOR COMPREHENSIVE
HEALTH CARE TO THE EXTENT HEREIN
LIMITED AND DEFINED

Issued By

UnitedHealthcare Insurance Company of the River Valley

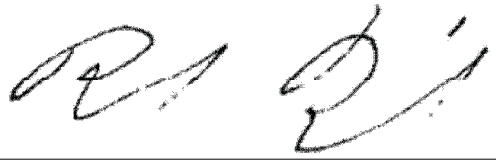
A Corporation Certified Under the Applicable Laws
of South Carolina, the State of Operation

CERTIFICATE OF COVERAGE
UNDER GROUP HEALTH CONTRACT

This Contract between the Subscriber who has enrolled and UnitedHealthcare Insurance Company of the River Valley ("UnitedHealthcare") is part of the Group Health Contract between UnitedHealthcare and Group through which the Member has enrolled. The Group Health Contract and this Contract, as defined in Article 1, form the entire contract.

This Contract entitles the Subscriber and Eligible Dependents to receive the benefits set forth herein during the Contract Period, subject to the terms and conditions of this Contract and upon payment of the Premium.

UnitedHealthcare Insurance Company of the River Valley

By: 

President

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ARTICLE 1 - DEFINITIONS

1.1 **Allowed Charge** - the portion of a charge for a Covered Service that UnitedHealthcare will consider in calculating benefits. The Allowed Charge is determined as follows:

1.1.1 **Participating Provider:** For Covered Services received from a Participating Provider, the Allowed Charge is the rate UnitedHealthcare has agreed to pay the Participating Provider under a contract.

1.1.2 **Non-Participating Provider - Medical Emergency:**
For Covered Services rendered by a Non-Participating Provider in a Medical Emergency the Allowed Charge is a rate agreed upon by the Non-Participating Provider or determined based upon the higher of:

- The median amount negotiated with Participating Providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

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

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

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Charge is based on 50% of the Non-Participating Provider's billed charge.

IMPORTANT NOTICE: Non-Participating Providers may bill the Member for, and the Member will be responsible for paying, any difference between the Non-Participating Provider's Billed Charges and the Allowed Charge described here. Any amount paid by a Member which is in excess of the Allowed Charge for Covered Services shall not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.

1.1.3 **Non-Participating Provider - Non Emergency.** For non-emergency Covered Services received from a Non-Participating Provider, including facility based Non-Participating Physicians providing non-emergency Covered Services in a Participating Hospital or facility, the Allowed Charge is set forth below:

- Negotiated rates agreed to by the Non-Participating Provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
- If rates have not been negotiated, then one of the following amounts:
  - Allowed Charges are based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar laboratory service.

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

- When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS,* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its Red Book), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
  - When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.

- For Mental Health Services and Substance Abuse Services the Allowed Charge will be reduced by 25% for Covered Services provided by a psychologist and by 35% for Covered Services provided by a masters level counselor.

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

  IMPORTANT NOTICE: Non-Participating Providers, including facility based Non-Participating Physicians providing non-emergency Covered Services in a Participating Hospital or facility, may bill the Member for, and the Member will be responsible for paying, any difference between the Non-Participating Provider's Billed Charges and the Allowed Charge described here. Any amount paid by a Member which is in excess of the Allowed Charge for Covered Services shall not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.

1.2 **Appeal** - a complaint which, having been reported by the Member and remaining unresolved to the Member's satisfaction is filed for formal proceedings as set forth in Article 17.

1.3 **Attending Physician** - a Physician who is primarily responsible for the care of Members with respect to any particular injury or illness.

1.4 **Billed Charge** - the amount a Provider bills for any services and supplies, whether or not the services or supplies are covered under this Contract. The Billed Charge may be different from the amount that UnitedHealthcare determines to be the Allowed Charge.

1.5 **Coinsurance** - a percentage of the Allowed Charge that the Member must pay for Covered Services received. The percentage is shown in Attachment D.

1.6 **Contract** - this Certificate of Coverage, any endorsements hereon and attached papers, if any, and the Subscriber's application constitute the entire Contract between UnitedHealthcare and the Subscriber.

1.7 **Contract Period** - refer to Attachment A.

1.8 **Copayment** - the amount, if any, the Member must pay for each Covered Service received, such as a doctor visit. The amount is specified per service and is shown in Attachment D. Each Copayment shall be paid at the time the service is provided.

1.9 **Covered Service** - a service, procedure, treatment, supply, device, or item specified in this Contract for which benefits will be provided when medically necessary.

1.10 **Deductible** - the dollar amount, if any, the Member must pay for health services before benefits are payable under this Contract. The amount is shown in Attachment D. Only those charges which would otherwise be payable by UnitedHealthcare in the absence of application of the Deductible shall count toward the Deductible.

1.10.1 The following amounts will not count toward any applicable Deductible:

1.10.1.1 Copayments (refer to Attachment D for specific benefit detail)

1.10.1.2 Amounts in excess of the MNRP rate, whether or not paid by the Member.

1.10.1.3 Amounts for Covered Services paid by the Member in connection with supplemental benefits, if any supplemental benefits rider is attached to this Contract, such as but not limited to prescription drug, dental, vision, or hearing.

1.10.1.4 Penalty amounts paid by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.

1.10.2 **4th Quarter Deductible Carryover:** Dollar amounts incurred by a Member during the last three months of a Contract Period , which were counted toward any applicable Deductible during that Contract Period of a UnitedHealthcare benefit plan with a 4th Quarter Deductible will also count toward any applicable Deductible for the following Contract Period .

1.11 **Eligible Dependent** - a person who meets UnitedHealthcare's eligibility requirements set forth in Attachment B. Eligible Dependent children may be covered up to the end of the month in which they turn 26.

1.12 **Emergency Services** - with respect to an Emergency Medical Condition:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).:

1.13 **Gender Dysphoria** - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- *Diagnostic criteria for children:*

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

1.14 **Group** - the sole proprietor, partnership, association or corporation, including any and all successors, through which the Member has enrolled, and which has agreed to collect and remit the Premiums payable under this Contract.

1.15 **Home Health Services** - skilled nursing care, when a Member is confined to his or her home related to a recuperative or treatable illness or injury and when provided by a Home Health Agency.

1.16 **Home Health Agency** - a public or private agency that specializes in providing skilled nursing services in the home, and is duly licensed to operate as a Home Health Agency under applicable state or local laws.

1.17 **Hospital** - an acute care general Hospital providing Hospital Services to Members.

1.18 **Hospital Services** - bed and board of the character classed as semiprivate or intensive care and all other services customarily furnished in a Hospital or Skilled Nursing Facility.

1.19 **Maximum Out-of-Pocket Expense** - the sum total amount of Copayments, Coinsurance, and Deductibles, as shown for an individual or family in Attachment D and paid by a Member, after which -for the remainder of the Contract Period - UnitedHealthcare will pay 100% of the Allowed Charge for that Member's subsequent Covered Services under this Contract.

1.19.1 The following amounts will not count toward any applicable Maximum Out-of-Pocket Expense, and the Member's responsibility for paying these amounts will continue even after the Member has met any applicable Maximum Out-of-Pocket Expense:

1.19.1.1 amounts in excess of the MNRP rate.

1.19.1.2 amounts payable by the Member in connection with supplemental benefits, if any supplemental benefits rider is attached to this Contract, such as but not limited to prescription drug, dental, vision, or hearing.

1.19.1.3 Penalty amounts payable by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.

1.20 **Medical Emergency** - The sudden onset of a medical condition that manifests itself by symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1.20.1 serious jeopardy to the mental or physical health of the Member;

1.20.2 danger of serious impairment of the Member's bodily functions;

1.20.3 serious dysfunction of any of the Member's bodily organs; or

1.20.4 in the case of a pregnant woman, serious jeopardy to the health of the fetus.

1.21 **Medicare** - Title XVIII of the Social Security Act, as amended from time to time.

1.22 **Member** - the Subscriber and any Eligible Dependents who are enrolled in UnitedHealthcare.

1.23 **Non-Participating Physician** - a Physician who has not entered into a Participating Physician's agreement with UnitedHealthcare Insurance Company of the River Valley , for the provision of health care services to Members.

1.24 **Non-Participating Provider** - any Provider licensed to provide medical services, including but not limited to a Physician, Hospital, or extended care facility, that does not have a contractual relationship with UnitedHealthcare Insurance Company of the River Valley , for the provision of health care services to Members.

1.25 **Participating Hospital** - an acute care general Hospital which has entered into a contractual relationship with UnitedHealthcare Insurance Company of the River Valley , for the provision of Hospital Services to Members.

1.26 **Participating Physician** - a Physician who has entered into a Participating Physician's agreement with UnitedHealthcare Insurance Company of the River Valley, for the provision of health care services to Members.

1.27 **Participating Provider** - any Provider, including but not limited to a Physician, Hospital, or extended care facility, that has entered into a contractual relationship with UnitedHealthcare Insurance Company of the River Valley , for the provision of health care services to Members.

1.28 **Penalty** - additional Member payment required as a result of Member's failure to comply with Preauthorization requirements for certain Covered Services from Non-Participating Providers as described in section 6.1.1. The amount is shown in Attachment D. Any Penalty amount paid by the Member will not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.

1.29 **Pharmaceutical Product(s)** - FDA-approved prescription pharmaceutical products administered in connection with a Covered Service by a Physician or other health care Provider within the scope of the Provider's license, and not otherwise excluded under this Certificate of Coverage.

1.30 **Physician** - a person who is properly licensed and qualified by law to practice medicine in any of its branches. Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under this Certificate of Coverage.

1.31 **Preauthorization** - as described in section 6.1.1, prior to the time certain services, items, and procedures are furnished, approval from UnitedHealthcare (or, for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider) for those services, items, and procedures to be covered. UnitedHealthcare establishes the criteria used to determine the appropriateness of the services, items, and procedures and the level of care that will be covered. If a Member has any question as to whether or not a service, item, or procedure requires Preauthorization, he or she should contact UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.

1.32 **Primary Care Physician (PCP)** - any Participating Physician who is designated by UnitedHealthcare Insurance Company of the River Valley as a Primary Care Physician.

1.33 **Provider** - any Provider licensed to provide medical services, including but not limited to a Physician, Hospital, or extended care facility.

1.34 **Premium** - the periodic amount of money currently charged by UnitedHealthcare for benefits and services provided under this Contract.

1.35 **Service Area** - the geographic area in which UnitedHealthcare offers this product to eligible employer groups.

1.36 **Skilled Nursing Facility** - an extended care facility which is accredited as a Skilled Nursing Facility under applicable state law or is recognized and eligible for payment under Medicare.

1.37 **Specialist** - any Participating Physician who is not designated by UnitedHealthcare Insurance Company of the River Valley as a Primary Care Physician.

1.38 **Subscriber** - an individual who is eligible to participate in the health benefit plan offered by Group under this Contract and who has enrolled under this Contract.

ARTICLE 2 - ELIGIBILITY DATE/EFFECTIVE DATE

2.1 The eligibility date shall be the date on which a Member is first deemed eligible by UnitedHealthcare to participate under this Contract.

2.2 Eligibility of Subscribers and Eligible Dependents shall be determined as set forth in Attachment B.

2.3 The coverage effective date shall be the date on which a Member is first deemed eligible by UnitedHealthcare to receive benefits under this Contract.

2.4 Benefits shall be provided when the Member receives services on or after the coverage effective date, except as set forth in section 2.6.

2.5 Upon the acquisition of an Eligible Dependent, the Subscriber shall make written notification to the Group within 31 days of such change and the coverage effective date will be the acquisition date of the Eligible Dependent. If written notification of the acquisition of an Eligible Dependent is made to the Group more than 31 days after such coverage change, the coverage effective date for such change will not be more than 31 days prior to the date the Group received proper notification.

2.6 **Changes in Eligibility Status.** Subscriber shall provide Group written notification of any dependent status change within 31 days of such change.

2.6.1 The Subscriber's failure to notify Group of a Member's loss of Eligible Dependent status shall not extend any person's coverage beyond the last day on which he or she qualifies as an Eligible Dependent.

2.6.2 *Canceling Coverage for Eligible Dependents:* When the Subscriber discontinues coverage for one or more Eligible Dependents, if notification of such change is received more than 31 days after the desired date of coverage change, the implemented date of the change will not be more than 31days prior to the date Group received proper notification to remove the Eligible Dependent(s) from coverage.

2.6.3 *Adding Eligible Dependents: See Special Enrollment,* section 2.7 of this Article.

2.7 **Special Enrollment.** UnitedHealthcare shall provide a Special Enrollment Period during which an eligible individual may enroll for coverage under this Contract under certain conditions. For purposes of this section, the term "Special Enrollment Period" means a period during which an eligible employee is allowed to request coverage for himself/herself and/or any Eligible Dependents upon the occurrence of certain events and conditions as described below in sections 2.7.1, 2.7.2, and 2.7.3.

2.7.1 *Prior coverage terminated or exhausted.* A Special Enrollment Period is available due to loss of group or other health insurance coverage as described in this section.

2.7.1.1 *Coverage loss which creates special enrollment opportunity.* Special enrollment is available to persons specified in section 2.7.1.2 when:

2.7.1.1.1 COBRA continuation coverage with a Prior Carrier is exhausted; or

2.7.1.1.2 Coverage under another group health plan or other health insurance coverage, which is not under COBRA continuation coverage, has terminated as a result of (a) loss of eligibility through legal separation, divorce, death, termination of employment or reduction in the number of hours worked, (b) cessation of employer contributions, (c) the plan no longer offers benefits to a class of individuals that include the eligible employee and/or Eligible Dependent, or (d) the eligible employee and/or Eligible Dependent loses eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

2.7.1.2 *Persons who may be entitled to special enrollment due to loss of prior coverage.* A Special Enrollment Period will be allowed for the persons described below when a loss of coverage described in section 2.7.1.1 has occurred, and if enrollment takes place during the Special Enrollment Period:

2.7.1.2.1 *For an eligible employee,* upon losing coverage under another plan.

2.7.1.2.2 *For an Eligible Dependent,* upon losing coverage under another plan, but only if such individual is an Eligible Dependent of an employee who is already covered under this Contract.

2.7.1.2.3 *For both the eligible employee and the employee's Eligible Dependent,* if either loses coverage under another plan.

2.7.1.3 In order to enroll due to loss of coverage as described above, the following conditions must be met:

2.7.1.3.1 The individual must be eligible to enroll under this Contract; and

2.7.1.3.2 The individual declined coverage under this Contract when the person first became eligible; and

2.7.1.3.3 When the individual declined such coverage, the individual was covered under another group's health plan or other health coverage; and

2.7.1.3.4 The employee stated in writing to UnitedHealthcare (if UnitedHealthcare required such a statement) that the existence of other coverage was the reason for declining enrollment for the employee and/or Eligible Dependents.

2.7.1.4 *Special Enrollment Period for Section 2.7.1.* To enroll due to loss of coverage, the employee must apply for coverage for the employee and/or Eligible Dependent within 31 days of loss of coverage, except that in order to enroll due to loss of eligibility for Medicaid or CHIP the employee must apply for coverage for the employee and/or Eligible Dependent within 60 days of loss of Medicaid or CHIP coverage.

2.7.1.5 *Dependent Child Special Open Enrollment Period.* On the first day of plan years, beginning on or after September 23, 2010, Group will provide a special 30 day special open enrollment period for Dependent children who have not yet reached the limiting age. During this special open enrollment period, employees who have a choice of coverage options will be allowed to change options.

Coverage begins on the date identified by Group if UnitedHealthcare receives the completed enrollment form and any required premium within 31 days of the date the Dependent child becomes eligible under this special open enrollment period.

2.7.2 *Acquisition of a Dependent.* A Special Enrollment Period will be allowed for the persons described below when the described events occur, and if they request coverage during the Special Enrollment Period stated in section 2.7.2.6.

2.7.2.1 *For an employee who is eligible but not enrolled:* when he/she marries or has a new child as the result of marriage, birth, adoption, interim court order for adoption or legal guardianshi p, or placement for adoption;

2.7.2.2 *For an individual who becomes a spouse of a Subscriber:* at the time of marriage, or when a child becomes an Eligible Dependent of that Subscriber as the result of birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.3 *For both an employee who is eligible but not enrolled and an eligible spouse:* when they marry or when a child becomes an Eligible Dependent of the employee as a result of birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.4 *For a child:* upon becoming an Eligible Dependent of a Subscriber as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.5 *For both an employee who is eligible but not enrolled and a child:* when the child becomes an Eligible Dependent of the employee as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.6 *Special enrollment period for section 2.7.2.* The employee must request coverage for the employee and/or Eligible Dependent/s within 31 days from the date of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption. Coverage for newly born, newly placed or adopted children is provided for 31 days. UnitedHealthcare must receive any required Premium and be notified of the birth, placement for adoption or adoption within 31 days after the birth, placement for adoption or adoption in order for coverage to continue beyond the initial 31 day period.

2.7.3 *Eligibility for State Premium Assistance Subsidy.* A Special Enrollment Period will be allowed for both an eligible employee and/or the employee's Eligible Dependent if the eligible employee and/or Eligible Dependent become eligible for a state premium assistance subsidy for employer group health coverage. To enroll pursuant to this Section 2.7.3, the employee must apply for coverage for the employee and/or Eligible Dependent within 60 days of the date of eligibility for the subsidy.

2.7.4 *Effective date of Enrollment.* For those enrolled during a Special Enrollment Period, enrollment is effective as follows:

2.7.4.1 *Loss of Coverage.* In the case of prior coverage being terminated or exhausted, not later than the first day of the first calendar month beginning after the date the request for enrollment is received.

2.7.4.2 *Marriage.* In the case of marriage, not later than the first day of the first calendar month beginning after the date the request for enrollment is received.

2.7.4.3 *Birth.* In the case of an Eligible Dependent's birth, on the date of such birth.

2.7.4.4 *Adoption, Interim Court Order for Adoption or Legal Guardianship, or Placement for Adoption.* In the case of an Eligible Dependent's adoption, interim court order for adoption or legal guardianship, or placement for adoption, on the date of such adoption, interim court order for adoption or legal guardianship, or placement for adoption.

2.7.4.5 *Eligibility for State Premium Assistance Subsidy.* In the case of the eligible employee and/or Eligible Dependent becoming eligible for a state premium assistance subsidy for employer group health coverage, not later than the first day of the first calendar month beginning after the date the request for enrollment is received.

2.7.5 For purposes of counting creditable coverage, the enrollment date for anyone who enrolls under a Special Enrollment Period is the first day of coverage. That is, the time between the date an individual becomes eligible for enrollment under this Contract and the first day of coverage is not treated as a waiting period.

ARTICLE 3 - PARTICIPATING AND NON-PARTICIPATING PROVIDERS

3.1 **Participating Providers.** When a Member uses Participating Providers, the Participating Providers are responsible for making arrangements with UnitedHealthcare for coverage of a Member's care, including but not limited to complying with the medical management requirements set forth in Article 6, and for submitting claims. Covered Services from Participating Providers will be paid at the "In-Network" level of benefits shown in Attachment D.

3.2 **Non-Participating Providers.** When a Member uses Non-Participating Providers, the Member is responsible for making arrangements with UnitedHealthcare for coverage of his or her care, including but not limited to complying with the medical management requirements set forth in Article 6, and for submitting claims for reimbursement in accordance with Article 11.

3.3 Charges for any service not payable to a Participating Provider will not be payable to a Non-Participating Provider.

3.4 Participating Providers are listed in the UnitedHealthcare Insurance Company of the River Valley provider directory for the Member's area. A Provider's status may change. Before obtaining services, a Member should verify the network participation status of a Provider in the Member's area. If a Member has any question as to whether or not a Provider is a Participating Provider, he or she should call UnitedHealthcare Insurance Company of the River Valley at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare Insurance Company of the River Valley web site also listed in Attachment C.

3.5 When a Member is admitted to a facility that has a contract with UnitedHealthcare Insurance Company of the River Valley , individual Providers within the facility may not be participating with UnitedHealthcare Insurance Company of the River Valley , including, but not limited to, Non-Participating Physicians on the staff of a Participating Hospital, home medical equipment suppliers, and other independent Providers. When a Member is referred to another Provider or admitted to a facility, the Member should always verify whether or not the individual Providers who provide services to Member are Participating Providers in the Member's area. If a Member has any question as to whether or not a Provider is a Participating Provider in the Member's area, he or she should call UnitedHealthcare Insurance Company of the River Valley at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare Insurance Company of the River Valley web site also listed in Attachment C.

ARTICLE 4 - GENERAL PROVISIONS FOR BENEFITS

4.1 Payment will not be made for any services provided to a Member unless such service is listed and described in Attachment D. If a Member has any question as to whether or not a specific service is covered, he or she should call UnitedHealthcare Insurance Company of the River Valley at the toll-free telephone number listed in Attachment C.

4.2 All services, whether provided by a Participating or a Non-Participating Provider, are subject to evaluation by UnitedHealthcare for appropriateness of care and case management if necessary.

4.3 Benefits will be paid only for a service, procedure, treatment, supply, device, or item, Hospital, medical or otherwise, which is medically necessary. To be medically necessary the service or treatment must meet the following criteria as determined by UnitedHealthcare and, if required by UnitedHealthcare, must be authorized on a prospective and timely basis by UnitedHealthcare:

4.3.1 The service or treatment is consistent with generally accepted principles of medical practice for the diagnosis and treatment of the Member's medical condition; and

4.3.2 The service or treatment is performed in the most cost-effective manner in terms of treatment, method, setting, frequency and intensity, taking into consideration the Member's medical condition.

4.4 UnitedHealthcare has the right to require Preauthorization in regard to any service provided by a Participating or Non-Participating Provider. Preauthorization requirements are set forth in section 6.1.1.

4.5 While a Member may consult with a Physician or other Provider about treatment which is excluded in Article 8 of this Contract or otherwise not covered, should the Member decide to follow a course of treatment which is excluded or not covered, UnitedHealthcare will not pay for such treatment.

ARTICLE 5 - SCHEDULE OF BENEFITS

5.1 Benefits listed under this Article will be paid subject to the provisions of Attachment D.

5.2 **Preventive Care Examinations and Associated Services.** Benefits are available for Preventive Care examinations (well-baby, well-child, well-adult care) and associated services including examinations and services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.

5.2.1 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.*

5.2.2 With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

5.2.3 Benefits include the following as required by South Carolina law:

5.2.3.1 Mammography screening which includes the following:

5.2.3.1.1 One baseline mammogram for Covered Persons at least 35 years of age but less than 40 years of age;

5.2.3.1.2 A mammogram every two years for Covered Persons at least 40 years of age but less than 50 year of age, or

5.2.3.1.3 In accordance with the most recently published guidelines of the *American Cancer Society.*

5.2.3.2 Annual pap smears.

5.2.3.3 Prostate cancer examinations, screenings, and laboratory tests in accordance with the most recent published guidelines of the *American Cancer Society.*

5.3 **Physician Medical Services.** Benefits are available for the following services when performed for the treatment of illness or injury and the diagnosis of infertility:

5.3.1 Office visits.

5.3.2 Office consultations.

5.3.3 Injections which are not usually self-administered.

5.3.4 Surgical care and associated anesthesia, including maternity care.

5.3.5 X-ray and laboratory tests and services, including pathology services and radiation therapy, for the treatment of illness or injury.

5.3.6 Blood transfusion services.

5.3.7 Hospital visits, Skilled Nursing Facility visits, and home visits.

5.3.8 Newborn care from the moment of birth, including well-care and care for the treatment of illness, injury, congenital defects, birth abnormalities and premature birth.

5.3.9 Casts and dressings

5.3.10 Medical eye exams (refer to Article 8.10 for exclusions)

5.3.11 All covered medical supplies furnished in connection with the services provided above.

5.4 **Allergy Testing and Injections.** Benefits are available as described in Attachment D.

5.5 **Inpatient Services.** Benefits are available for services received in an acute care Hospital or Skilled Nursing Facility for room and board at the semi-private or intensive care level, less any applicable Copayment, Coinsurance, or Deductible. For a private room, the Member shall pay directly to the facility the difference between its regular charge for the private room and its most common charge for a semiprivate room, as well as any applicable Copayment, Coinsurance or Deductible. However, if a private room is authorized as medically necessary by UnitedHealthcare, then the private room charge shall be covered, less any applicable Copayment, Coinsurance, or Deductible. Room and board includes all charges made by a Hospital on its own behalf for the room, meals, and for all general services and activities needed for the care of a registered bed patient. Also covered are the miscellaneous medical services and supplies used during the confinement such as, but not limited to, diagnostic x-rays and laboratory tests, and the administration of anesthesia, whole blood and blood derivatives. Also covered are services and supplies for a mastectomy or lymph node dissection. The attending Physician will determine the length of stay. Benefits include an Inpatient Stay for a minimum of 48 hours following a mastectomy. In the event of an early discharge, Benefits shall include at least one home health care visit if ordered by the attending Physician.

In an intensive care unit, a Member shall be entitled to all services of the intensive care unit, including special duty nursing.

5.6 **Outpatient Hospital and Ambulatory Care Services.** Charges incurred as a result of surgery performed as an outpatient or in an ambulatory care setting are covered.

5.7 **Emergency Services.** Whenever possible, a Member should contact his or her Physician prior to receiving treatment for a Medical Emergency. If the Physician is not immediately available, the Member should seek emergency care at the most convenient health care facility.

5.7.1 **Emergency Services.** When a Medical Emergency occurs, the Member should seek care immediately from a Hospital or other emergency facility or call 911 (the emergency telephone system). If it is determined that a Medical Emergency existed, or that the visit to the Hospital or other emergency facility was medically necessary, the initial visit will be covered. Follow-up care received in a Hospital or an emergency facility is not covered; the Member must arrange follow-up care with a Physician.

5.7.2 **Determination of Covered Benefits.** Benefits will be paid for Emergency medical care services provided to a Covered Person who presents with an Emergency medical condition. The determination of covered benefits for services rendered in a Hospital or emergency facility is based on UnitedHealthcare's review of the Member's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. If it is determined that a Medical Emergency did not exist, or that services were not medically necessary, the Member will be held financially responsible for those services. As a general rule, for UnitedHealthcare to determine that a Medical Emergency existed or that services were medically necessary, the date of the onset of symptoms and the date of treatment as reported on the claim form should be the same but not more than 24 hours after an illness or injury.

5.7.3 **Notification After Services are Received.** If due to the severity of his or her condition, the Member was unable to notify his or her Physician prior to seeking emergency care, the Member should notify his or her Physician within 48 hours after treatment is rendered, or as soon as reasonably possible. If the Member is unable to notify due to his or her condition, or if the patient is a minor, this 48-hour period will be reasonably extended until the Member or a responsible adult is able to notify.

5.8 **Ambulance Services.** For Medical Emergencies, ambulance services (either ground or air) will be covered to the nearest facility that is equipped and staffed to provide necessary services. Preauthorization is not required to access an emergency 911 system or other state, county or municipal emergency medical system for ambulance services. For non-emergencies, when medically necessary, a Member shall be entitled to coverage for ambulance services to a Hospital, between Hospitals when needed specialized care cannot be obtained at the first Hospital, and between a Hospital and a Skilled Nursing Facility.

5.9 **Home Health Services.** A Member confined to his or her home may be entitled to skilled nursing services provided by a Home Health Agency. Such visits shall include part-time or intermittent home health care by or under the supervision of a registered nurse. A skilled nursing visit of four hours or less shall equal one home health visit. Before Home Health Services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

5.10 **Hospice Services.** Benefits are provided for outpatient Hospice Services to a Member with a Terminal Illness. Before Hospice Services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

5.10.1 For the purposes of this section, the following definitions apply:

5.10.1.1 "Hospice Services" means a coordinated program of outpatient care provided directly by or under the direction of a Medicare-certified hospice agency or Medicare-certified home health agency, and includes Palliative Care and supportive physical, psychological, psychosocial and other health services, utilizing a medically-directed interdisciplinary team.

5.10.1.2 "Member with a Terminal Illness" means a Member whose condition has been diagnosed as terminal by a licensed Physician, whose medical prognosis is death within six months, and who has elected to receive Palliative Care rather than curative care.

5.10.1.3 "Palliative Care" means treatment directed at controlling pain, relieving other symptoms, and focusing on the Member's special needs while experiencing the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of curing or of prolonging life.

5.10.2 There may be clinical situations when short episodes of acute care would be appropriate even when the Member remains in the hospice setting. While these acute care services are not payable under the Hospice Services benefit, they may be Covered Services under other sections of this Contract.

5.11 **Durable Medical Equipment.** Benefits are payable for the rental of Durable Medical Equipment for home use in the treatment of an injury or illness or for the improvement of the function of a malformed body member. In some cases, UnitedHealthcare may determine that purchase of the equipment is more appropriate than rental. Benefits will not be paid for special features or equipment requested by the Member for personal comfort or convenience.

"Durable Medical Equipment" means medical equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) is not useful in the absence of illness or injury, and (d) is appropriate for home medical treatment.

5.12 **Prosthetic Devices.** Coverage for Prosthetic Devices includes (a) initial placement of a Prosthetic Device and its supportive device, (b) maintenance and repair required for the successful use of the device, (c) replacement of a device when required by growth or change in medical condition, and (d) replacement of a device due either to wear and tear or to technological improvement and determined to be medically necessary.

"Prosthetic Devices" means those devices which replace all or part of a body organ (including contiguous tissue) or a diseased, malformed, or injured portion of the body or replace all or part of the function of a permanently inoperative or malfunctioning bodily organ or portion of the body.

5.13 **Organ and Tissue Transplants.** Organ and tissue transplant services described in this section must be ordered by the Member's Attending Physician and received from transplant centers approved by UnitedHealthcare; otherwise, benefits will not be paid. Before organ and tissue transplant services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

Benefits for all organ and tissue transplant services will be payable as shown in Attachment D. This restriction applies to all services performed in conjunction with the transplant. Transplant services for a

Member who is the recipient of an organ or tissue transplant include all professional, technical and facility charges (inpatient and outpatient) for evaluation of the transplant procedure and follow-up care (twelve months). If the recipient is a Member, professional, technical and facility charges for removal of the donated organ or tissue, as well as any complication resulting from the donation, are also covered by UnitedHealthcare for a live primary donor up to 90 calendar days after the date of the donation, if such donation is not covered by other insurance. Organ and tissues covered for transplant include: heart, heart/lung, kidney, kidney/pancreas, liver, lung, bone marrow and stem cell.

If a Member is registered at two or more transplant centers for the same transplant (i.e. "multiple listing"), UnitedHealthcare will pay for Covered Services associated with only one approved transplant center waiting list. UnitedHealthcare will not pay for any charges related to additional transplant center waiting lists.

UnitedHealthcare has specific guidelines regarding benefits for transplant services. The Member should contact UnitedHealthcare at the telephone number on the back of the ID card for information about these guidelines.

5.14 **Cornea Transplants.** Benefits are available as described in Attachment D.

5.15 **Outpatient Rehabilitative Therapy.** Outpatient rehabilitative therapy benefits will be paid for conditions resulting from disease or injury or when prescribed immediately following surgery related to the condition. Outpatient rehabilitative therapy includes physical, occupational, manipulative treatment and speech therapy and cardiac (phase I and II) and pulmonary rehabilitation. Therapy must be ordered by a Physician and performed by a licensed therapist acting within the scope of his or her licensure.

5.15.1 Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational or recreational therapy. Occupational therapy performed by an occupational therapist will be covered to the extent that such therapy is performed to regain use of the upper extremities.

5.15.2 Speech therapy will be covered only for treatment of a residual speech impairment resulting from a stroke, cleft lip/cleft palate, accidental injury or surgery to the head or neck or for treatment of a pervasive developmental disorder.

5.15.3 Cardiac rehabilitation requires continuous ECG monitoring to be covered. Only monitored (Phase I and II) cardiac rehabilitation is covered.

5.15.4 Pulmonary rehabilitation program is payable once per lifetime for a Member. Pulmonary rehabilitation does not count toward any applicable maximum number of Outpatient Rehabilitative Therapy treatment visits shown in Attachment D.

5.16 **X-ray and Laboratory Services.** Benefits are payable for diagnostic x-ray and laboratory services performed for the diagnosis and/or treatment of an illness or injury, including, but not limited to, x-ray films and scans, such as computerized axial tomography (CAT) scans, electrocardiograms (EKGs), ultrasound examinations, mammography, and blood, urine and pathology (tissue) tests.

- Annual chlamydia screening test.
- Ovarian cancer surveillance test for women age 35 and older, who are at risk for ovarian cancer.

5.17 **Radiation Therapy and Chemotherapy.** Benefits are payable for radiation therapy (such as x-ray and radium) received in connection with the treatment of malignancies and certain other tumors; and generally accepted chemotherapy received for the treatment of malignancies.

5.18 **Mental Health Services.** Benefits for Hospital Services or medical care for mental health shall be covered, and coverage will be neither different nor separate from coverage for any other illness, condition, or disorder, for the purposes of determining any limitations and Deductible, Copayment, and Coinsurance. Any day of confinement, service provided, or examination must have Preauthorization from UnitedHealthcare's mental health treatment program provider, except when a Medical Emergency exists. The Member may contact UnitedHealthcare's mental health treatment program provider at the toll-free telephone number listed on the back of the Member's UnitedHealthcare identification card to request a list

of Participating Providers for UnitedHealthcare Insurance Company of the River Valley or for more information on the procedures to be followed.

Mental Health Services include behavioral services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavioral Analysis (ABA))* that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavioral 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 Service for which benefits are available under the applicable medical Covered Services categories in this *Subscriber Agreement.*

5.18.1 **Inpatient Facility Services.** If a Member is confined as a resident inpatient in a Hospital, Non-Acute Hospital, or other residential treatment facility and enrolled in a treatment program for a psychiatric, mental, or nervous condition or disorder, benefits will be paid according to the provisions of Attachment D and section 5.5.

5.18.2 **Outpatient Facility Services.** Outpatient facility service benefits will be paid if a Member receives Hospital outpatient medical services at a Hospital, Non-Acute Hospital, or other treatment facility and is enrolled in an outpatient treatment program for a psychiatric, mental, or nervous condition or disorder. Benefits will be paid according to the provisions of Attachment D and section 5.6.

"Non-Acute Hospital" as used in this section means a facility which is not licensed to operate as an acute care general Hospital.

5.18.3 **Physician Services.** If a Member shall receive psychiatric or professional services by a Physician acting within the scope of his or her licensed authority, or other licensed mental health Provider, for a psychiatric, mental or nervous condition or disorder, benefits will be paid subject to Attachment D and the following provisions:

5.18.3.1 **Hospital Inpatient Physician Services.** Hospital inpatient Physician services benefits will be paid if the Member is confined as a resident inpatient in a Hospital as described in section 5.5.

5.18.3.2 **Hospital Outpatient Physician Services.** Hospital outpatient Physician services benefits will be paid if the Member receives Hospital outpatient services as described in section 5.6.

5.18.3.3 **Physician Office Services.**

5.18.4 **Exclusions and Limitations Applicable to Mental Health Benefits.** See Article 8.41.

5.19 **Substance Abuse Services.** Benefits for Hospital Services or medical care for substance abuse including alcoholism shall be covered, and coverage will be neither different nor separate from coverage for any other illness, condition, or disorder, for the purposes of determining any limitations and Deductible, Copayment, and Coinsurance. Any day of confinement, service provided, or examination must have Preauthorization from UnitedHealthcare's substance abuse treatment program provider, except when a Medical Emergency exists. The Member may contact UnitedHealthcare's substance abuse treatment program provider at the toll-free telephone number listed on the back of the Member's UnitedHealthcare identification card to request a list of Participating Providers with UnitedHealthcare Insurance Company of the River Valley or more information on the procedures to be followed.

5.19.1 **Inpatient Facility Services.** If a Member is confined as a resident inpatient in a Hospital, Non-Acute Hospital, or other residential treatment facility and enrolled in a treatment program for substance abuse, benefits will be paid according to the provisions of Attachment D and section 5.5.

5.19.2 **Outpatient Facility Services.** Outpatient facility service benefits will be paid if a Member receives Hospital outpatient medical services at a Hospital, Non-Acute Hospital, or other treatment facility and is enrolled in an outpatient treatment program for substance abuse. Benefits will be paid according to the provisions of Attachment D and section 5.6.
"Non-Acute Hospital" as used in this section means a facility which is not licensed to operate as an acute care general Hospital.

5.19.3 **Physician Services.** If a Member shall receive psychiatric or professional services by a Physician acting within the scope of his or her licensed authority, or other licensed mental health Provider, for substance abuse, benefits will be paid subject to Attachment D and the following provisions:

5.19.3.1 **Hospital Inpatient Physician Services.** Hospital inpatient Physician services benefits will be paid if the Member is confined as a resident inpatient in a Hospital as described in section 5.5.

5.19.3.2 **Hospital Outpatient Physician Services.** Hospital outpatient Physician services benefits will be paid if the Member shall receive Hospital outpatient services as described in section 5.6.

5.19.3.3 **Physician Office Services.**

5.19.4 **Exclusions and Limitations Applicable to Substance Abuse Benefits.** See Article 8.41.

5.20 **Reconstructive Surgery.** Benefits are provided for reconstructive surgical procedures which are medically necessary to repair a functional disorder as a result of disease, injury or congenital anomaly. Benefits are also provided for: all stages of reconstructive breast surgery as a result of a mastectomy; reconstructive surgery necessary to re-establish symmetry between the two breasts; prostheses; and treatment of physical complications including treatment of lymphedemas at all stages of the mastectomy. Benefits for reconstructive surgery as a result of a mastectomy are provided in a manner determined in consultation with the attending Provider and the patient.

5.21 **Maternity Care.** Benefits are provided for maternity care, including prenatal and post-natal care and care for complications of pregnancy. With regard to post-parturition care, coverage is as follows: (a) a minimum of 48 hours of inpatient care for the mother and newborn, following a vaginal delivery, or (b) a minimum of 96 hours of inpatient care for the mother and newborn, following a delivery by caesarian section. These time periods do not include the date of delivery. A shorter length of stay for services related to maternity and newborn care may be provided if after consultation with the mother or upon consent of the mother the Attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn. The attending provider may also request additional time. If a shorter length of stay is determined to be appropriate in accordance with these guidelines, the mother and newborn shall have coverage for an office visit or home-nurse visit within 48 hours of discharge.

5.22 **Diabetes Self-Management/Supplies.** Benefits are provided for equipment and supplies (including, but not limited to, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, and lancets). Outpatient self-management training and education must be provided in person by a certified, registered, or licensed health care professional who is authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the *Diabetes Initiative of South Carolina.* Note that benefits for diabetic equipment and supplies are provided and paid through a supplemental benefits rider for prescription drugs attached hereto.

5.23 **Certain Clinical Trials for Treatment Studies on Cancer approved by National Cancer Institute (NCI) or National Institutes of Health (NIH).**

5.23.1 Coverage is provided for Patient Costs, as defined below, incurred by Member during participation in any phase of clinical trials for treatment studies on cancer but only when all of the following conditions are met:

5.23.1.1 There is no clearly superior, non-investigational treatment alternative;

5.23.1.2 The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative;

5.23.1.3 The Member and Member's Attending Physician conclude that the Member's participation in the clinical trial would be appropriate;

5.23.1.4 The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise; and

5.23.1.5 The treatment is provided by a clinical trial approved by one of the following: (a) the NCI, (b) an NCI Cooperative Group, or (c) an NCI center or the federal Department of Veterans Affairs. "Cooperative Group" means a formal network of facilities that collaborate on research projects and have an established NCI-approved peer review program operating within the group. Cooperative Group includes the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

5.23.2 Coverage of Patient Costs incurred during participation in a clinical trial shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures.

5.23.3 "Patient Costs" means the costs of Covered Services that are incurred as a result of the treatment being provided to Member for purposes of a clinical trial. Patient Costs do not include:

5.23.3.1 the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial;

5.23.3.2 costs associated with managing the research associated with the clinical trial;

5.23.3.3 the cost of the investigational procedure, drug, pharmaceutical, device, or clinical trial therapies, regimens, or combinations thereof;

5.23.3.4 costs associated with the provision of any goods, services, or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer;

5.23.3.5 additional costs associated with the provision of any goods, services, or benefits that previously have been provided to, paid for, or reimbursed, or any similar costs; or

5.23.3.6 treatments or services prescribed for the convenience of the Member or his or her Attending Physician.

5.24 **Hearing Aids.** Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Participating Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. Hearing aids are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

5.25 **Urgent Care Facility Services.** Services received at an Urgent Care Facility are available as described in Attachment D.

5.26 **Cleft Lip and Cleft Palate Services.** Benefits for the following:

5.26.1 Oral and facial surgery, surgical management and follow-up care.

5.26.2 Prosthetic treatment, such as obdurators, speech appliances, and feeding appliances.

5.26.3 Orthodontic treatment and management.

5.26.4 Prosthodontia treatment and management.

5.26.5 Otolaryngology treatment and management.

5.26.6 Audiological assessment, treatment and management, including surgically implanted amplification devices.

5.26.7 Physical therapy assessment and treatment.

If a Covered Person with a cleft lip or palate is also covered by a dental policy, teeth capping, prosthodontics and orthodontics shall be payable under the dental policy to the limit of coverage provided, and any excess thereafter shall be covered under this Policy.

5.27 **Neurobiological Disorders - Autism Spectrum Disorder Services.**

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

5.27.1.1 Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

5.27.1.2 Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

5.27.2 This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under this Article. Benefits include the following services provided on either an inpatient or outpatient basis:

5.27.2.1 Diagnostic evaluations and assessment.

5.27.2.2 Treatment planning.

5.27.2.3 Referral services.

5.27.2.4 Medication management.

5.27.2.5 Individual, family, therapeutic group and provider-based case management services.

5.27.2.6 Crisis intervention.

5.27.3 Benefits include the following services provided on an inpatient basis:

5.27.3.1 Partial Hospitalization/Day Treatment.

5.27.3.2 Services at a Residential Treatment Facility.

5.27.4 Benefits include the following services provided on an outpatient basis:

5.27.4.1 Intensive Outpatient Treatment.

UnitedHealthcare determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semiprivate Room basis.

We encourage you to contact UnitedHealthcare for referrals to providers and coordination of care.

5.28 **Gender Dysphoria.** Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services in the Certificate.*
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is described under in the *Certificate.*
    - Cross-sex hormone therapy dispensed from a pharmacy is provided as described in the Outpatient Prescription Drug Rider.
    - Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:
The Member must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Member must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

5.29 **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-dir ected medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

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

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

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.

- Physician.

- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal
- We may require the following be provided:
- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow us to prove that medical treatment is needed.
- When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:
- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

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

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

5.30 **Virtual Visits**

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

ARTICLE 6 - MEDICAL MANAGEMENT PROCESSES

6.1 UnitedHealthcare utilizes the following medical management processes for services from Participating and Non-Participating Providers:

6.1.1 **Preauthorization.** Some services, items, and procedures, including certain medical and diagnostic procedures, require approval by UnitedHealthcare prior to the time those services, items, and procedures are furnished ("Preauthorization"). UnitedHealthcare establishes the criteria used to determine the appropriateness of the services, items, and procedures and the level of care that will be covered.

6.1.1.1 *When a Member uses Participating Providers:* The Member *is not* responsb ile for obtaining Preauthorization. Participating Providers are responsible for complying with Preauthorization requirements.

6.1.1.2 *When a Member uses Non-Participating Providers:* The Member *is* responsible for obtaining Preauthorization.

6.1.1.3 *When a Member fails to obtain Preauthorization:* If the Member fails to obtain Preauthorization for services, items, or procedures from Non-Participating Providers, and UnitedHealthcare determines the services, items, or procedures were medically necessary, the services, items, or procedures will be covered, but the Member will pay a Penalty, in addition to any applicable Deductible and/or Coinsurance, as set forth in Attachment D. Any Penalty amount paid by the Member will not count toward any applicable Deductible or Maximum Out-of-Pocket Expense. If UnitedHealthcare determines that the services, items, or procedures were not medically necessary, the Member will be responsible for paying the Non-Participating Provider all charges for such services, items, and procedures.

6.1.1.4 If a Member has any question as to whether or not a service, item, or procedure requires Preauthorization, the Member should call UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.

6.1.1.5 When Preauthorization is required prior to rendering treatment, UnitedHealthcare will have personnel available to provide such Preauthorization.

6.1.1.6 Section 6.1.1 also applies to mental health and substance abuse services, as described in sections 5.19 and 5.20, with the following exception: Preauthorization must be obtained from UnitedHealthcare's mental health and/or substance abuse treatment program provider. The toll-free telephone number for UnitedHealthcare's mental health and/or substance abuse treatment program provider is listed on the Member's UnitedHealthcare identification card.

6.1.2 **Hospital or Nursing Facility Continued Stay Review.** Continued stays at a facility may be reviewed for appropriateness of care and services. This review will be performed by UnitedHealthcare. If a continued stay is determined by UnitedHealthcare to be no longer medically necessary, UnitedHealthcare may contact the Attending Physician to determine the need for the continued stay and request a plan of treatment. Any charges for services provided following the determination by UnitedHealthcare that services are not medically necessary will not be paid by UnitedHealthcare and will not be counted toward any applicable Deductible or Maximum Out-of-Pocket Expense limits.

6.1.3 **Case Management.** UnitedHealthcare may engage in the medical management of certain treatment of Members from time to time to help assure that appropriate health care is being provided to the Member. This medical management may also coordinate various aspects of care provided to seriously ill or injured Members.

ARTICLE 7 - MEMBER PAYMENTS DIRECTLY TO PROVIDERS

7.1 If any services not included in or covered by this Contract are provided to a Member, or if any Copayments, Coinsurance, Deductibles, and/or Penalty amounts apply as shown in Attachment D, the Member shall make direct payment to the Provider of such services.

ARTICLE 8 - EXCLUSIONS APPLICABLE TO THE CONTRACT

In addition to specific exclusions listed under individual Articles, benefits shall not be provided for any of the following:

8.1 Any service or treatment, Hospital, medical, or otherwise, which is not medically necessary as described and defined in section 4.3, or any medical complication resulting from a service, treatment, procedure, or device which is not covered under this Contract.

8.2 Shift care, 24-hour nursing, private or special duty nursing services in the Hospital, home or Skilled Nursing Facility.

8.3 Care for conditions that federal, state or local law requires be treated in a public facility, Hospital, or other health care facility.

8.4 If the Member's condition is custodial, which means that his or her care consists of watching, maintaining, protecting or is for the purpose of providing personal needs, UnitedHealthcare does not pay for a person or facility to provide any of, but not limited to, the following:

8.4.1 assistance in the activities of daily living, such as walking, dressing, getting in and out of bed, bathing, eating, feeding or using the toilet or help with other functions of daily living or personal needs of a similar nature;

8.4.2 changes of dressings, diapers, protective sheets or periodic turning or positioning in bed;

8.4.3 administration of or help in using or applying medications, creams and ointments, whether oral, inhaled, topical, rectal or injection;

8.4.4 administration of oxygen;

8.4.5 care or maintenance in connection with casts, braces, or other similar devices;

8.4.6 care in connection with ostomy bags or devices or in-dwelling catheters;

8.4.7 feeding by tube including cleaning and care of the tube site;

8.4.8 tracheostomy care including cleaning, suctioning and site care;

8.4.9 urinary bladder catheterization;

8.4.10 monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device used to support a physiological function including, but not limited to, a ventilator, phrenic nerve or diaphragmatic pacer; or

8.4.11 general supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

8.5 Hospital, personal care or convenience items or services including, but not limited to: television, telephone, newborn infant photos, complimentary meals, birth announcements, or other articles which are not for specific treatment of illness or injury. Also, benefits are not provided for:

8.5.1 private room or special diets unless medically necessary;

8.5.2 housekeeping, homemaker service, and caregiver room/board;

8.5.3 purchase or rental of household equipment or fixtures such as air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses, waterbeds, escalators, elevators, saunas, or swimming pools; or

8.5.4 charges for diversional activities such as recreational, hobby or craft equipment or fees.

8.6 Surgical excision or reformation of any sagging skin on any part of the body including but not limited to eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with enlargement, reduction, implantation, or change in appearance in any portion of the body including but not limited to, breasts, face, lips, jaw, chin, nose, ears or genitals; hair transplantation; chemical face peels or abrasions of skin; electrolysis depilation; treatment of birthmarks or superficial veins; any other surgical or non-surgical procedures which are performed for cosmetic purposes. However, benefits will be payable for certain reconstructive surgery as described in section 5.21.

8.7 Any fees for the services of Providers that are not Physicians if the fees or charges therefore are claimed by Hospitals, laboratories, or other institutions or for the service of any assisting Physician not authorized by a Provider.

8.8 Dental care.

8.8.1 Any fees involving any types of services in connection with dentistry are excluded, including but not limited to:

8.8.1.1 the care, filling, removal or replacement of teeth or of the structures supporting the teeth;

8.8.1.2 surgical augmentation for orthodontics or maxilla (upper jaw) or mandible (lower jaw) construction; or

8.8.1.3 orthognathic surgery, which refers to any surgical procedure performed to correct skeletal malposition or misalignment of the maxilla and/or mandible, including osteotomy or condylotomy.

8.8.2 Exceptions to this exclusion are as follows:

8.8.2.1 Reconstructive surgery as provided in section 5.21;

8.8.2.2 Surgical and non-surgical procedures resulting directly from: (a) neoplasms that require treatment to the jaws, cheeks, lips, tongue, or roof or floor of mouth; or (b) accidental injury to natural permanent teeth for which the Member seeks treatment within 60 days of the injury. "Injury" does not include fractures of restorations or teeth resulting from routine daily functions. Preauthorization is required prior to any such treatment, procedure or service described in this section;

8.8.2.3 If dental coverage is provided in a supplemental benefits rider attached hereto;

8.8.2.4 Coverage for Cleft Lip and Cleft Palate Services as described in section 5.29.

8.9 The following items, unless provided in a supplemental benefits rider attached hereto:

8.9.1 dental prostheses; or

8.9.2 eye glasses or contact lenses (except after cataract surgery)

8.10 Routine eye examinations or refractions, including examinations for astigmatism, myopia, or hyperopia, unless a supplemental benefits rider is attached hereto.

8.11 Augmentative communication devices, unless medically necessary.

8.12 Special shoes unless an integral part of a brace or part of diabetes treatment; corrective footwear; foot orthotic devices and supplies unless part of diabetes treatment; routine foot care, including trimming of corns, calluses and nails unless part of diabetes treatment; corsets, other articles of clothing, or cosmetic devices. This exclusion does not apply to persons with diabetes.

8.13 Treatment provided in a government Hospital; services performed by a Member for a Member's immediate family; and services for which no charge is normally made.

8.14 Services for any illness, injury or disease that is covered, in whole or in part, by any employer's plan or coverage designed to comply with any state or federal workers' compensation, employer's liability or occupational disease law (collectively, workers' compensation law), or, with respect to the Subscriber, any illness, injury or disease that could be covered, in whole or in part, by such plan or coverage if the

employer had such plan or coverage. If UnitedHealthcare makes payment for such services, it shall be entitled to a lien upon any amounts it paid for which the employer's workers' compensation plan or coverage should have been liable.

8.15 Any service which can be performed in the setting by a person who does not have professional qualifications but has been trained to perform the service.

8.16 Experimental, Unproven and/or investigational drugs, devices, medical treatment or procedures.

8.16.1 A drug, device, treatment or procedure is experimental and/or investigational if:

8.16.1.1 the drug or device requires approval of the Food and Drug Administration and the drug or device has not been approved when furnished (a drug or device approved for experimental and/or investigational use is deemed to be experimental and/or investigational);

8.16.1.2 the drug, device, treatment or procedure is being provided according to a written protocol which describes as an objective determining the safety, toxicity, efficacy or effectiveness of the drug, device, treatment, or procedure as compared with the standard means of treatment or diagnosis for the Member's medical condition; or

8.16.1.3 Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's medical condition.

8.16.2 For the purposes of this Article, "Reliable Evidence" shall mean only published reports and articles in the authoritative medical and scientific literature.

8.16.3 Treatment provided in a phase I, II, or III clinical trial will be deemed to be experimental and/or investigational unless Reliable Evidence establishes that the treatment is not experimental and/or investigational for the Member's medical condition. Exception: "Patient Costs" incurred as a result of a Member's participation in certain National Cancer Institute-approved and National Institutes of Health-approved clinical trials for cancer are covered as described in section 5.24.

8.17 Biofeedback treatment except in conjunction with physical therapy performed for the treatment of urinary incontinence.

8.18 Holistic medicine; massage therapy; acupuncture; hypnotherapy; sleep therapy; vocational, rehabilitation or employment counseling; marriage and sex counseling; behavior training, conduct disorders and related family counseling; remedial education and treatment of learning disabilities.

8.19 Charges of a Non-Participating Provider in excess of the MNRP rate, unless due to a Medical Emergency.

8.20 Drugs, medicines, or any implants or devices used in conjunction with birth control regardless of the intended use, unless provided in a supplemental benefits rider attached hereto.

8.21 Ergometers, exercise bikes, or other similar devices.

8.22 Diet or weight loss programs, nutritional counseling, dietary supplements, nutritional formulas and supplements, and megavitamin therapy. Exceptions to this exclusion are as follows:

8.22.1 Preventive care for which benefits are provided under the *United States Preventive Services Task Force* requirement; or

8.22.2 Medical nutritional therapy will be covered for up to two medically necessary visits per calendar year for hypertension and myocardial infarction; or

8.22.3 Medical nutritional therapy will be covered under a diabetes self-management program as described in section 5.23.

8.23 Illness contracted or injuries sustained as the result of war, declared or undeclared, or any act or hazard of war.

8.24 Illness contracted or injuries sustained as the result of or while in the armed services of any country to the extent that the Member is entitled to coverage for such sickness or injury through any governmental plan or program except Medicaid.

8.25 Outpatient prescription drugs unless a supplemental benefits rider is attached hereto, and other drugs or medications except when provided to Member in an inpatient setting.

8.26 Hospital or Physician services or treatment provided as a result of a court order unless Preauthorization has been obtained from UnitedHealthcare.

8.27 Charges incurred in connection with any assisted reproduction techniques, regardless of the reason for treatment, such as, but not limited to, artificial insemination and in vitro fertilization, donor services, reversal of vasectomies, reversal of tubal ligations or the reversal of other voluntary sterilization procedures.

8.28 Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

8.29 Cryopreservation and other forms of preservation of reproductive materials, regardless of the reason for preserving the materials.

8.30 Surgery to the cornea or any other part of the eye to improve vision by changing the refraction, such as but not limited to radial keratotomy or LASIK (laser assisted in-situ keratomileusis).

8.31 Physical exams and any related diagnostic testing required for employment, licensing, insurance, adoption, immigration, school, camp or sports participation when services will result in duplication of UnitedHealthcare benefits for preventive care. Immunizations for the purpose of obtaining or maintaining employment are also excluded.

8.32 Any fees relating to any types of services or items resulting from an injury sustained as a result of the injury was the Member's commission of, or attempt to commit, a felony.

8.33 Performance of an injection by a nurse or Physician which would normally be self-administered, except in an inpatient setting.

8.34 Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational or recreational therapy.

8.35 Organ and tissue transplant services provided by Participating Providers that are not UnitedHealthcareapproved transplant centers or by Non-Participating Providers. Charges associated with more than one transplant center waiting list are also excluded. Organ and tissue transplant services are payable only as described in section 5.13.

8.36 Telephone or email consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for copying medical records.

8.37 Charges for non-used medication.

8.38 Replacement of items that are lost, stolen, misused, otherwise abused, or damaged due to neglect or accident.

8.39 Charges in excess of any lifetime benefit maximum amount shown in Attachment D for any Member.

8.40 Charges in excess of any benefit maximum or limitation shown in Attachment D.

8.41 The following mental health and substance abuse services:

8.41.1 services, other than diagnostic services, for mental retardation or for non-treatable mental deficiency;

8.41.2 treatment of a mental or nervous disorder which is not subject to favorable modification by accepted psychiatric treatment;

8.41.3 treatment of marital problems;

8.41.4 family therapy, except as related to a Covered Service for another family member;

8.41.5 treatment of learning problems;

8.41.6 treatment of adult or childhood antisocial behavior without manifestation of a psychiatri c disorder;

8.41.7 treatment of aggressive or nonaggressive conduct disorder without manifestation of a psychiatric disorder; and

8.41.8 charges for personal and convenience items such as telephone, television, personal care items and personal services or for charges for diversional activities such as recreational, hobby or craft equipment or fees.

8.42 Services provided to a Member as a part of a demonstration project conducted or sponsored by the Centers for Medicare & Medicaid Services (CMS).

8.43 In the event a Non-Participating Provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

8.44 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.

ARTICLE 9 - GENERAL CONDITIONS UNDER WHICH BENEFITS SHALL BE PROVIDED

9.1 The benefits of this Contract are subject to all terms and conditions described herein.

9.2 Under this Contract, UnitedHealthcare has the right to make any benefit payment to the Provider of Covered Services, or directly to the Member. UnitedHealthcare is specifically authorized by the Member to determine to whom any benefit payment should be made. In the event a Member has to pay a Non-Participating Provider for Covered Services at the time services are rendered, UnitedHealthcare will send payment for Covered Services to the Member in accordance with section 11.3, less any applicable Copayment, Coinsurance, Deductible, and/or Penalty amount.

9.3 Hospital Services are subject to all the rules and regulations of the Hospital or Skilled Nursing Facility, including the rules and regulations governing admission and discharge.

9.4 The Member agrees that any complaint regarding this Contract or the provision of benefits under this Contract shall be submitted for resolution in accordance with the Member Complaint, Appeal, and Dispute Resolution Procedure established by UnitedHealthcare as set forth in Article 17.

9.5 It is only in the event of fraud or misrepresentation of a material fact in enrolling or making claim for benefits under this Certificate of Coverage, including but not limited to the unauthorized use of a Member's UnitedHealthcare identification card by any other person, that UnitedHealthcare shall have the right to recover the full amount of any benefits paid on behalf of the Member. Should your coverage be rescinded due to fraud, or an intentional misrepresentation of a material fact, we may take any and all actions

allowed by law, which may include demanding that you pay back all Benefit we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. If coverage is rescinded, we will provide 30 days prior written notice.

9.6 In the event of any major disaster or epidemic, war, riot or labor dispute, UnitedHealthcare shall provide coverage for Hospital Services and medical services covered under this Contract in so far as practical, according to its best judgment, within the limitations of such facilities and personnel as are then available. Under such conditions UnitedHealthcare shall not have any liability or obligation for delay or failure to provide coverage or arrange for Hospital Services or medical services due to lack of available facilities or personnel.

9.7 The Member agrees to provide UnitedHealthcare all information relating to duplicate insurance or other coverage for which there may be coordination of benefits.

ARTICLE 10 - RELATIONSHIP AMONG PARTIES AFFECTED BY THE CONTRACT

10.1 The relationship between UnitedHealthcare and any person or organization having a contract with UnitedHealthcare is an independent contractor relationship. No such organization or employee or agent thereof is an employee or agent of UnitedHealthcare and neither is UnitedHealthcare nor any employee or agent of UnitedHealthcare an employee or agent of such organization.

10.2 Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services.

10.3 The Member is not an agent or representative of UnitedHealthcare, and shall not be liable for any acts or omissions of UnitedHealthcare, its agents or employees, or any other person or organization with which UnitedHealthcare has made or hereafter shall make arrangements for the performance of services under this Contract.

10.4 UnitedHealthcare has entered into a service agreement with its parent UnitedHealthcare Services Company of the River Valley, Inc. UnitedHealthcare Services Company of the River Valley, Inc. provides all administrative services for UnitedHealthcare.

ARTICLE 11 - CLAIM PROVISIONS

11.1 Except as set forth in Attachment D, it is not anticipated that a Member will make payment to any Participating Provider performing a Covered Service under this Contract beyond any applicable Copayment, Coinsurance, or Deductible. However, if the Member furnishes evidence satisfactory to UnitedHealthcare that he or she has made payment to a Participating Provider for performing a Covered Service under this Contract, payment for those charges will be made to the Member, but in no event will the amount of payment to the Member exceed the maximum benefit payable by UnitedHealthcare less any applicable Copayment, Coinsurance, or Deductible.

11.2 If a charge is made to a Member by a Participating Provider for performing a Covered Service under this Contract beyond any applicable Copayment, Coinsurance, or Deductible, written proof of such charges should be furnished to UnitedHealthcare within 90 days from the date of service. Payment for such charges will not be made to the Member if evidence of payment is submitted more than fifteen months after the date of service.

11.3 Charges for a Covered Service performed by a Non-Participating Provider will be paid to the Member, or to the Non-Participating Provider if there is a written assignment of benefits, after written proof of charges is furnished to UnitedHealthcare within one year from the date the service was performed. Payment for such charges will not be made to the Member, or to the Non-Participating Provider through a written assignment of benefits, if written proof of such charges is not furnished to UnitedHealthcare within this one year period.

11.4 We shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted via paper within 40 business days after the later of the following dates:

11.4.1 Our receipt of the claim.

11.4.2 The date on which we are in receipt of all information needed and in a format required for the claim to constitute a clean claim, and we are in receipt of all documentation which may be requested by, and reasonably needed by, us in order to do either of the following:

11.4.2.1 Determine that such claim does not contain any material defect, error, or impropriety .

11.4.2.2 Make a payment determination.

11.5 We shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted electronically within 20 business days of either of the following dates:

11.5.1 Our receipt of the claim.

11.5.2 The date on which we are in receipt of all information needed and in a format required for the claim to constitute a clean claim and we are in receipt of all documentation which may be requested by, and reasonably needed by, us in order to either:

11.5.2.1 Determine that such claim does not contain any material defect, error, or impropriety .

11.5.2.2 Make a payment determination.

11.6 We shall affix to paper claims, or otherwise maintain a system for determining, the date we receive claims. We shall send an electronic acknowledgement of claims submitted electronically either to the provider or the provider's designated vendor for the exchange of electronic health care transactions. The acknowledgement must identify the date we receive claims. If we determine that there is any defect, error, or impropriety in a claim that prevents the claim from entering our adjudication system, we shall provide notice of the defect or error either to the provider or the provider's designated vendor for the exchange of electronic health care transactions within 20 business days of the submission of the claim if it was submitted electronically or within 40 business days of the claim if it was submitted via paper. Nothing contained in this section is intended or may be construed to alter our ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

11.7 A clearinghouse, billing service, or any other vendor that contracts with a provider to deliver health care claims to us on the provider's behalf is prohibited from converting electronic claims received from the provider into paper claims for submission to us. A violation of this subsection constitutes an unfair trade practice under *Chapter 5, Title 39,* and individual providers and insurers injured by violations of this subsection have an action for damages as set forth in Section 39-5-140 of South Carolina insurance law.

ARTICLE 12 - PREMIUMS

12.1 Only Members for whom the Group has paid the Premium shall be entitled to benefits for the period for which such payment has been received. UnitedHealthcare will allow Group a grace period of 31 days following the Premium due date. For non-payment of Premium, we will send a written notice to you within 14 days of the end of the grace period. This notice will include information regarding your continuation and conversion rights. In the event of non-payment of Premium, your coverage will end 60 days after we send written notice of termination to you This Contract shall stay in force during the grace period. If payment is not received before the end of the grace period, coverage will be terminated at the end of the grace period with prior notice to Group and Members. If we end the entire Policy because we will no longer issue this particular type of group health benefit plan within the applicable market, we will provide

written notification to you at least 90 days prior to the Enrolling Group's renewal date. If we end the entire Policy because we will no longer issue any type of health benefit plan, we will provide written notification to you and the applicable state authority at least 180 days prior to the Enrolling Group's renewal date.

12.2 The Group or its delegate is the plan administrator under federal law and is responsible for various duties as plan administrator including, but not limited to, notice to Members of suspension or termination of coverage and reporting and disclosure requirements. UnitedHealthcare is not the plan administrator . The Group, or its delegate, but not UnitedHealthcare, is responsible for complying with the health care continuation provisions in the Consolidated Omnibus Budget Reconciliation Act of 1975 (COBRA), as amended, or any state law.

ARTICLE 13 - TERMINATION

13.1 In addition to termination for non-payment of Premium as explained in section 12.1, UnitedHealthcare may terminate this Contract at any time for one or more of the following reasons:

13.1.1 Death of the Subscriber: Upon the death of the Subscriber this Contract shall automatically terminate. For coverage rights, if any, of surviving Eligible Dependents, see Article 14 and Article 15.

13.1.2 Subscriber no longer eligible: If the Subscriber is no longer eligible to participate in the health benefits plan offered by the Group under this Contract, this Contract shall automatically terminate. For coverage rights, if any, of Subscriber and Eligible Dependents, see Article 14 and Article 15.

13.1.3 Fraud or Intentional misrepresentation of a Material Fact: UnitedHealthcare will provide at least 30 days advance required notice to the Member that coverage will end on the date UnitedHealthcare identifies in the notice because the Member 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. The Member may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If UnitedHealthcare finds that the Member has performed an act, practice, or omission that constitutes fraud, or has made an intentional misrepresentation of material fact UnitedHealthcare has the right to demand that the Member pays back all benefits UnitedHealthcare paid to the Member, or paid in the Member's name, during the time the Member was incorrectly covered under the policy.

13.1.4 Unauthorized use of a Member's UnitedHealthcare identification card by any other persons: Under such circumstances, UnitedHealthcare may retain the identification card and all rights of such Member and, if such Member is a Subscriber, all rights of his or her Eligible Dependents shall terminate.

13.1.5 Change in status as Eligible Dependent: If a Member is no longer within the definition of an Eligible Dependent, his or her benefits shall terminate. For coverage rights, if any, see Article 14 and Article 15.

13.1.6 Failure on the Member's part to pay Copayments, Coinsurance, Deductibles, or Penalty amounts.

13.1.7 Member engages in activities which endanger the safety and welfare of UnitedHealthcare or its employees or providers.

13.1.8 Expiration of the maximum continuation of coverage period as described in Article 14.

13.1.9 Such other reasons as may be approved by the appropriate regulatory agencies of the state of operation.

13.2 If the Group Health Contract which covers the Member terminates, this Contract shall terminate at the same time. If required by law, UnitedHealthcare shall give Member written notice prior to termination.

13.3 Upon termination of enrollment as provided in this Article or Article 12, Member shall cease to be entitled to any benefits under this Contract. However, if Member remains in a Hospital or Skilled Nursing Facility at the time of such termination, Member shall be entitled to an extension of benefits, subject to the terms and conditions of this Contract, for that confinement. Such an extension of benefits for Hospital or Skilled Nursing Facility services shall cease with the earliest occurrence of one of the following events:

13.3.1 Member is discharged from the Hospital or Skilled Nursing Facility;

13.3.2 Member becomes covered under another group health plan; or

13.3.3 60 days has elapsed from the date this Contract terminated.

13.4 Except as provided in this Article, UnitedHealthcare must renew this Contract at the option of the Group, unless:

13.4.1 The Group fails to pay Premiums or contributions in accordance with the terms of this Contract.

13.4.2 The Group performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the coverage or, with respect to coverage of a Member, fraud, or intentional misrepresentation by the Member or the Member's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, UnitedHealthcare has the right to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.

13.4.3 The Group violates participation or contribution rules.

13.4.4 No Member of the Group lives, resides, or works in the Service Area.

13.4.5 UnitedHealthcare ceases to offer a particular type of health insurance coverage in such market in accordance with applicable state law. If UnitedHealthcare decides to discontinue such product that has been purchased by the Group, UnitedHealthcare will meet the following requirements:

13.4.5.1 Provide written notice to Group and each Subscriber covered under this Contract, of the discontinuation of such product at least 90 days before the discontinuation of coverage;

13.4.5.2 Offer to Group the option on a guaranteed basis to purchase any other health insurance coverage currently being offered by UnitedHealthcare in such market; and

13.4.5.3 In exercising the option to discontinue such product and in offering the option of coverage under section 13.4.5.2, UnitedHealthcare will act uniformly without regard to claims experience of those Groups or any health status-related factor relating to any Members who may become eligible for such coverage.

13.4.6 UnitedHealthcare elects to discontinue offering all health insurance coverage in the State of South Carolina. Health insurance coverage may be discontinued by UnitedHealthcare only in accordance with applicable state law and if:

13.4.6.1 UnitedHealthcare provides written notice to the South Carolina Department of Insurance and to Group and each Subscriber covered under this Contract, at least 180 days prior to the discontinuation of coverage; and

13.4.6.2 All affected group health contracts issued or delivered for issuance in the State of South Carolina are discontinued and coverage is not renewed.

13.5 A certificate of creditable coverage will be provided in accordance with state and federal law. Also, a Member may request a certificate of creditable coverage by contacting UnitedHealthcare at the appropriate address or toll-free telephone number listed in Attachment C.

ARTICLE 14 - CONTINUATION OF COVERAGE

14.1 **Continuation Coverage Under Federal Law.** If benefits under this Contract terminate due to a loss of eligibility according to the eligibility requirements established by UnitedHealthcare, continuation of coverage shall be provided if required under the terms and conditions of any applicable federal laws. A Member should contact his or her Group's plan administrator to determine if he or she is eligible to continue coverage under applicable federal or state law.

14.2 Continuation shall not be made available for any Member or for any Eligible Dependent of a Subscriber who has exhausted any Lifetime Benefit Maximum shown in Attachment D.

14.3 **Continuation Coverage Under State Law.** You are eligible for continuation coverage if your coverage ended due to termination of the Subscriber for any reason other than nonpayment of required contributions. You must have been continuously covered under this Contract (or under any Contract providing similar benefits which it replaces) for at least 6 months immediately prior to termination. You are not eligible for continuation coverage if:

14.3.1 You are eligible for other group medical coverage which provides similar benefits.

14.3.2 You are eligible for Medicare.

14.3.3 You are eligible for continuation under federal law for a greater period of time than this section provides.

14.4 **Notification Requirements and Election Period for Continuation Coverage Under State Law.** The Group will provide you with written notification of the right to continuation coverage prior to termination of coverage under this Contract. You must elect continuation coverage within 60 days of receiving written notification of termination.

14.5 You should obtain an election form from the Group or the employer and, once election is made, forward all monthly Premiums to the Group for payment to us. Premiums are limited to 100% of the Premium that an actively-at-work Member must contribute. Continuation begins upon payment in advance to the Group for the first month's Premium. Payment must include any portion of the Premium usually paid by the Group.

14.6 **Terminating Events for Continuation Coverage under State Law.** Continuation coverage is subject to this Contract remaining in force and your paying the required Premium amount before the first day of each month. Continuation coverage under this Contract will end on the earliest of the following dates:

14.6.1 6 months, plus any remaining fraction of a Policy month, from the date your continuation began.

14.6.2 The date coverage ends for failure to make timely payment of the Premium.

14.6.3 The date this entire Contract ends.

14.7 **Extended Coverage for Total Disability.** Coverage for a Member who is Totally Disabled on the date this entire Contract is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

14.7.1 The Total Disability ends.

14.7.2 Twelve months from the date coverage would have ended when this entire Contract was terminated.

ARTICLE 15 - CONVERSION PRIVILEGE

15.1 If a Member ceases to be covered under this Contract due to the cessation of eligibility for coverage under the Group Health Contract or upon cancellation or non-renewal of the Group Health Contract, the Member is entitled to have issued to him or her, without evidence of insurability, or imposition of any pre-existing

condition limitations or exclusions for Members under age 19, an individual conversion policy. If the Member is a Subscriber with Eligible Dependents, a family conversion contract may be purchased that will cover the Subscriber and Eligible Dependents who were covered under the Group Health Contract on the date of cancellation of coverage. To obtain the conversion contract, the Member shall submit a written application and the applicable Premium payment within 31 days after the Member's coverage is terminated. UnitedHealthcare may require Copayments, Coinsurance, Deductibles, or Penalty amounts under the conversion contract that differs from the Group Health Contract. Information regarding conversion coverage options will be provided by the local UnitedHealthcare office at the request of the Member.

15.2 Conversion Privilege for a Former Spouse.

15.2.1 An Enrolled Dependent who ceases to be eligible due to divorce from the Subscriber may make application to us for coverage under a conversion contract without furnishing evidence of insurability.

15.2.2 Application and payment of the initial Premium must be made within 60 days of the entry of the decree of divorce.

15.2.3 An individual contract shall be issued in accordance with the terms and conditions in effect at the time of application. Any probationary or waiting periods set forth in the individual contract are considered as being met to the extent coverage was in force under the Policy.

15.3 A conversion contract will not be made available if:

15.3.1 Cancellation of the Member's coverage occurred due to the reasons set forth in sections 13.1.3, 13.1.4, 13.1.6, 13.1.7, or 13.1.9;

15.3.2 The Member is covered by or is eligible for benefits under Medicare;

15.3.3 The Member is covered by or is eligible for similar Hospital, medical or surgical benefits under state or federal law;

15.3.4 The Member is covered by or is eligible for similar Hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group whether on an insured or uninsured basis;

15.3.5 The Member is covered for similar benefits through individual coverage;

15.3.6 The Member has not been continuously covered during the three month period immediately preceding cancellation of the Member coverage;

15.3.7 The Member has moved outside of the Service Area;

15.3.8 The Group Health Contract has been discontinued in its entirety, and there is a Succeeding Carrier providing coverage to the Group in its entirety; or

15.3.9 The Member has exhausted any Lifetime Benefit Maximum shown in Attachment D.

15.4 Effective date of the conversion contract will be on the date of termination from the Group Health Contract.

ARTICLE 16 - REINSTATEMENT AND MISCELLANEOUS PROVISIONS

16.1 Any Contract which is terminated in any manner as provided herein may be reinstated by UnitedHealthcare as it determines.

16.2 This Contract is personal to the Member and shall not be assigned, delegated, or transferred.

16.3 Applicants for enrollment shall complete and submit to UnitedHealthcare such applications, medical review questionnaires, or other forms or statements as UnitedHealthcare may reasonably request. Applicants agree that all information contained in such materials shall be true, correct and complete to the best of their knowledge and belief.

16.4 Members may request additional identification cards, free of charge, by contacting UnitedHealthcare at the toll-free telephone number listed in Attachment C. Any cards issued by UnitedHealthcare to Members pursuant to this Contract are for identification only. Possession of a UnitedHealthcare identification card confers no right to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Contract have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to the provisions of this Contract shall be charged at prevailing rates.

16.5 UnitedHealthcare may receive rebates from pharmaceutical manufacturers. Rebates are the exclusive property of UnitedHealthcare and will not be considered when determining a Member's cost-sharing obligations, such as any applicable Copayment, Coinsurance, or Deductible.

16.6 UnitedHealthcare may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract.

16.7 **Entire Contract; Changes.**

16.7.1 This Contract constitutes the entire Contract between the parties and, as of the effective date hereof, supersedes all other agreements, oral or otherwise, between the parties regarding the subject matter of this Contract and may not be altered or amended except in writing.

16.7.2 No agent or other person, except an officer of UnitedHealthcare, has authority to waive any conditions or restrictions of this Contract; to extend the time for making a payment; or to bind UnitedHealthcare by making any promise or representation or by giving or receiving any information. No change in this Contract shall be valid unless evidenced by an endorsement on it signed by one of the aforesaid officers, or by an amendment to it signed by the Group and by one of the aforesaid officers, and filed with the South Carolina Department of Insurance or other appropriate regulatory agencies of the state of operation.

16.8 By electing coverage pursuant to this Contract, or accepting benefits under this Contract, all Members and their applicable legal representatives expressly agree to all terms, conditions and provisions of this Contract.

16.9 **Legal Actions.** No civil action shall be brought to recover on this Contract before 60 days after written proof of loss has been filed as required in accordance with the requirements of this Contract. You must complete all the steps in the appeal process described in Article 17. After completing that process, if you want to bring a legal action against us you must do so within six years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

16.10 **Subrogation.**

16.10.1 If we pay Benefits for medical expenses you incur for treatment of Injuries resulting from any act for which there is a liable third party, and you later obtain a recovery, you are obligated to reimburse us for the Benefits paid. Our right of subrogation is limited to the amount of Benefits that we have paid previously in relation to your Injury by the liable third party. In addition, we must pay attorneys' fees and costs from the amounts recovered.

16.10.2 You have the right to petition the *Director* of the *South Carolina Department of Insurance* to determine whether the exercise of subrogation by us is inequitable and commits an injustice to you, and, therefore, should not be allowed. This determination by the *Director* or the *Director's* designee may be appealed to the *Administrative Law Judge Division.*

16.10.3 Liable third party includes 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.

16.10.4 Nothing herein shall limit our right to recovery from another source which may otherwise exist at law.

ARTICLE 17 - MEMBER COMPLAINT, APPEAL, AND DISPUTE RESOLUTION PROCEDURES

17.1 This Article sets forth a formal system for resolving Complaints and Appeals by Members concerning coverage determinations, the provision of health care services or other matters concerning the operation of UnitedHealthcare.

17.2 The following definitions apply to this Article 17:

17.2.1 "Appeal" means a Complaint, which having been reported to UnitedHealthcare by the Member and remaining unresolved to the Member's satisfaction, is filed for formal proceedings as set forth in this Article.

17.2.2 "Authorized Representative" means the Member's guardian or an individual the Member has authorized to act on his or her behalf, including but not limited to the Member's Physician.

17.2.3 "Complaint" means an oral or written expression of dissatisfaction relating to the policies of or the services provided by UnitedHealthcare. This includes pre-service and post-service claims and urgent situations.

17.2.4 "Grievance procedure" means a hearing for the Member, regarding denial of payment in whole or in part for health care services, treatment or claims after all other steps outlined in this Article have been completed.

17.2.5 "Post-Service Claim" means any claim for a benefit that is not a Pre-Service Claim.

17.2.6 "Pre-Service Claim" means any claim for a benefit with respect to which the terms of the Contract condition receipt of the benefit, in whole or part, based on approval of the benefit in advance of obtaining medical care.

17.2.7 "Urgent Care Claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (b) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

17.3 **How to Request an Appeal.** Most Complaints can be resolved satisfactorily on an informal basis by consultation between the Member, UnitedHealthcare staff, and/or the health care practitioner from whom the Member has received services. If a Member's Complaint is not resolved through informal consultation, the Member or Member's Authorized Representative may request a formal Appeal either orally or in writing. If the Member wants to designate an Authorized Representative to assist him or her with the Appeal, this must be done in writing. A Member's Authorized Representative may not file a formal Appeal without explicit, written designation by the Member. For Pre-Service and Post-Service Claims that are not Urgent Care Claims, the Member or Member's Authorized Representative may request an Appeal by completing a written "Appeal Form," which shall be provided by UnitedHealthcare upon the written or oral request of the Member or Member's Authorized Representative. The Appeal Form must be completed and filed to UnitedHealthcare within 180 days from the date (a) the Member received notification of a denial of coverage or (b) the problem in question occurred. The Appeal Form shall be completed and signed and the facts as alleged shall be binding on Member. The Appeal Form shall be filed by mail, facsimile, or hand-delivery to UnitedHealthcare, in accordance with instructions provided with the Appeal Form.

17.4 **Expedited Appeal Procedure for Urgent Care Claims.** For Urgent Care Claims, the Member or Member's Authorized Representative may contact UnitedHealthcare, orally or in writing, to request expedited consideration of the Member's formal Appeal.

17.4.1 In determining whether a claim is for urgent care, UnitedHealthcare will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If the request for expedited consideration is denied by UnitedHealthcare, the Member's or Member's Authorized Representative's Appeal will automatically be reviewed by UnitedHealthcare according to the Appeal Procedure provided in section 17.5. The request for expedited consideration will not be denied if a Physician with knowledge of the Member's medical condition determines that a claim involves urgent care. The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

17.4.2 Within 2 working days after UnitedHealthcare receives a request for expedited handling which includes all necessary information, UnitedHealthcare will issue a decision to You or Your Authorized Representative by telephone or facsimile.

17.5 **Appeal Process-Level 1** A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. Within 30 thirty calendar days after receiving all information necessary to complete the appeal. If the appeal is denied, the notification will contain justification for the denial. In extraordinary circumstances, the thirty-day period to determine appeals may be extended for not more than sixty days If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. UnitedHealthcare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The Member consents to this referral and the sharing of pertinent medical claim information.

17.6 **Grievance Procedure-Level 2** If you continue to disagree with our decision, you or your Authorized Representative shall have 30 calendar days from the date the Appeal decision was issued pursuant to section 17.5, in which to file a request for reconsideration to the Grievance Committee of UnitedHealthcare. For Appeals related to determinations which require medical judgment, including determinations of medical necessity, the Member or Member's Authorized Representative may request an Independent Physician Review (IPR) as described in section 17.7.

17.6.1 The Committee meeting shall be held at the UnitedHealthcare home office in Moline, Illinois. If you are not able to appear in person, we will arrange for you to communicate with the Committee by a conference call or you may submit additional information and comments in writing. We will appoint a Committee, composed of representatives who were not involved in the previous determination. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

17.6.2 The Member Reconsideration Committee shall resolve the Appeal by majority vote within 15 calendar days from the receipt of the Appeal request for Pre-Service claims within 30 calendar days for Post-Service claims.

17.6.3 Please note that you may contact the South Carolina Department of Insurance at any time. If you file a complaint, they will provide a copy to us. We will respond within 10 calendar days to the department that sent us your complaint.

17.7 **External Review by an Independent Review Organization**

17.7.1 In certain situations, you may be entitled to an additional review of your appeal at our expense. An external review may be used to reconsider your appeal if we have denied it, either in whole or in part; and a requested service or payment for service has been denied, reduced or terminated. These situations include a decision by us that your requested service is either of the following:

17.7.1.1 It does not meet our requirements for Medical Necessary, appropriateness, health care setting, level of care, or effectiveness.

17.7.1.2 It is an Experimental or Investigational or Unproven Service, and involves a condition that is life threatening or seriously disabling.

17.7.2 After your internal appeals are completed, you will be notified in writing of your right to request an external review. There are two types of external reviews. The first is a standard external review and the second is an expedited external review.

17.8 **Standard External Review**

17.8.1 You should file a written request for a standard external review within 4 months of receiving the notice of your right to an external review. If payment was denied, reduced or terminated because we determined the treatment was an Experimental or Investigational or Unproven Service, you must enclose a letter or certificate from your treating Physician. See the requirements for this certificate below under *Physician Certification Requirements.* You will be required to authorize the release of any medical records that may need to be reviewed for the purpose of reaching a decision during the external review.

17.8.2 Within five business days of your request for a standard external review, we must respond by either:

17.8.2.1 Assigning your review and forwarding records we relied upon in making our decision to an independent review organization.

17.8.2.2 Telling you in writing that your situation does not meet the requirements for an external review and the reasons for our decision. If you have questions, you may contact the *South Carolina Department of Insurance.*

17.8.3 Within five business days of receiving your case, an independent review organization must do both of the following:

17.8.3.1 Decide if it has the information necessary to review your case.

17.8.3.2 Notify you if it needs more information. If more information is required, you have seven business days after you receive the request for information to respond to the independent review organization.

17.8.4 The independent review organization will notify you within 45 days of its decision.

17.9 **Expedited External Review**

17.9.1 Expedited reviews are available if your Physician certifies that you have a serious medical condition (one that requires immediate medical attention to avoid serious impairment to bodily functions, serious harm to an organ or body part, or that would place your health in serious jeopardy).

17.9.2 You may also receive an expedited review if our denial concerns an admission, availability of care, continued stay, or health care service for which you received Emergency Health Services and have not been discharged from a facility, if you are being held financially responsible for the Emergency Health Services.

17.9.3 You should file a written request for an expedited external review after receiving notice of your right to an external review. You must enclose a letter from your treating Physician stating that you have a serious medical condition. If payment was denied, reduced or terminated because we determined the treatment was an Experimental or Investigational or Unproven Service, you must enclose a letter or certificate from your treating Physician. See the requirements for this certificate below under *Physician Certification Requirements.* You will be required to authorize the release of any medical records that may need to be reviewed for the purpose of reaching a decision during the external review.

17.9.4 As soon as is reasonably possible after receipt of your request for an expedited external review, we must respond by either:

17.9.4.1 Assigning your review and forwarding records we relied upon in making our decision to an independent review organization.

17.9.4.2 Telling you in writing that your situation does not meet the requirements for an external review and the reasons for our decision. If you have questions, you may contact the *South Carolina Department of Insurance.*

17.9.5 The independent review organization must notify you within three working days of its decision.

17.10 **Final Determination for the Independent Review Organization.** For both standard external reviews and expedited external reviews, when an independent review organization finds in your favor, we will approve the Benefit. If the independent review organization does not find in your favor, you cannot request another review for the same denial.

17.11 **Physician Certification Requirements**

17.11.1 If our denial of coverage is based on a determination that the health care service or treatment recommended or requested is an Experimental or Investigational or Unproven Service, the request for review must include a certification from your treating Physician, who must be a licensed Physician qualified to practice in the area of medicine appropriate to treat your condition, that all of the following apply:

17.11.1.1 You have a life-threatening disease or seriously disabling condition.

17.11.1.2 At least one of the following situations is applicable:

17.11.1.2.1 Standard health care services or treatments have not been effective in improving your condition.

17.11.1.2.2 Standard health care services or treatments are not medically appropriate for you.

17.11.1.2.3 The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us.

17.11.1.3 Medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment you requested is more beneficial than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard service or treatments.

17.11.2 For the purpose of this section, the following terms mean:

17.11.2.1 "Life-threatening condition" is a condition or disease which, according to the current diagnosis by the treating Physician, has a high probability of causing the Covered Person's death within three years.

17.11.2.2 "Seriously disabling" is a health condition or Illness that involves a serious impairment to bodily functions or a serious dysfunction of a bodily organ or part.

17.12 Upon written request and free of charge, the Member or Member's Authorized Representative may request copies of all documents relevant to an Appeal or reconsideration.

17.13 For further information about any procedure in this Article 17, the Member may contact either UnitedHealthcare or the South Carolina Department of Insurance at the addresses or toll-free telephone numbers provided in Attachment C.

ARTICLE 18 - NOTICE

18.1 Any notice given by UnitedHealthcare to the Member shall be sufficient if mailed to the Member at his or her address as it appears on the records of UnitedHealthcare. It is the Member's responsibility to notify the personnel department of his or her Group of any and all changes in address. Any notice shall be deemed delivered when deposited in the United States mail at any post office or postal box with first class postage prepaid.

ARTICLE 19 - RIGHT OF REIMBURSEMENT

19.1 Immediately upon paying or providing any Benefit, UnitedHealthcare shall have the right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

19.1.1 Third parties, including any person alleged to have caused you to suffer injuries or damages.

19.1.2 Your employer.

19.1.3 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.

19.1.4 Any person or entity who is liable for payment to you on any equitable or legal liability theory.

19.2 These third parties and persons or entities are collectively referred to as "Third Parties." You agree as follows:

19.3 That you will cooperate with us in protecting our legal rights to reimbursement, including, but not limited to:

19.3.1 providing any relevant information requested by us,

19.3.2 signing and/or delivering such documents as we or our agents reasonably request to secure reimbursement claim,

19.3.3 responding to requests for information about any accident or injuries,

19.3.4 making court appearances, and

19.3.5 obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

19.4 That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

19.5 That benefits paid by us may also be considered to be benefits advanced.

19.6 That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.

19.7 That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this reimbursement clause shall apply to that claim.

19.8 We agree that our right of recovery shall be limited only to the recovery of Benefits paid for covered medical services under the Policy and shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered.

ARTICLE 20 - COORDINATION OF BENEFITS

Coordination of Benefits with This Plan and Other Coverage

20.1 **Applicability.**

20.1.1 This COB provision does not apply to any supplemental benefits rider for prescription drugs under This Plan.

20.1.2 This Coordination of Benefits (COB) provision applies to This Plan when a Member has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

20.1.3 If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

20.1.3.1 shall not be coordinated when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

20.1.3.2 may be coordinated when, under the order of benefit determination rules, another Plan determines its benefits first. The above coordination is described in section 20.4, Effects on the Benefits of This Plan.

20.2 **Definitions.**

20.2.1 "Plan" is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

20.2.1.1 Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment or group practice coverage. It also includes coverage other than school accident-type coverage.

20.2.1.2 Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program.

Each contract or other arrangement for coverage under section 20.2.1.1 or 20.2.1.2 is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

20.2.2 "This Plan" is the part of the Group Health Contract that provides benefits for health care expenses.

20.2.3 "Primary Plan"/"Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

20.2.4 "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, subject to the terms and conditions of this Contract, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. This Plan shall not have payment liability as secondary carrier for charges not covered under this Contract unless the Member has established a credit within the Coordination of Benefits reserve bank.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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

20.3 **Order of Benefit Determination Rules.**

20.3.1 **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

20.3.1.1 the other Plan has rules coordinating its benefits with those of This Plan; and

20.3.1.2 both those rules and This Plan's rules, in section 20.3.2 below, require that This Plan's benefits be determined before those of the other Plan.

20.3.2 **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

20.3.2.1 Non-dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or Subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

20.3.2.2 Dependent Child/Parents Not Separated or Divorced. Except as stated in section below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

20.3.2.2.1 the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but

20.3.2.2.2 if both parents have the same birthday, the benefits of the Plan which has covered the parent longer are determined before those of the Plan which has covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in section 20.3.2.2.1 above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not a gree on the order of benefits, the rule in the other Plan will determine the order of benefits.

20.3.2.3 Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

20.3.2.3.1 first, the Plan of the parent with custody of the child;

20.3.2.3.2 then, the Plan of the spouse of the parent with the custody of the child, and

20.3.2.3.3 finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of the parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

20.3.2.4 Active/Inactive Employees. The benefits of the Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule 20.3.2.4 is ignored.

20.3.2.5 Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or Subscriber longer are determined before those of the Plan which covered that person for the shorter time.

20.4 **Effects on the Benefits of This Plan.**

20.4.1 **When This Section Applies.** This section 20.4 applies when, in accordance with section 20.3, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be coordinated under this section. Such other Plan or Plans are referred to as "the other Plans" in 20.4.2 below.

20.4.2 **Coordination in this Plan's Benefits.** The benefits of This Plan will be coordinated when the sum of:

20.4.2.1 the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

20.4.2.2 the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be coordinated so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are coordinated as described above, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of This Plan.

20.5 **Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. UnitedHealthcare has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. UnitedHealthcare need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts it needs to pay the claim.

20.6 **Facility of Payment.** A payment under another Plan may include an amount which should have been paid under this Plan. If it does, UnitedHealthcare may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. UnitedHealthcare 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.

20.7 **Right of Recovery.** If the amount of the payments made by UnitedHealthcare is more than it should have paid under this COB provision, it may recover the excess from one or more of:

20.7.1 the persons it has paid or for whom it has paid;

20.7.2 insurance companies; or

20.7.3 other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

20.8 **Worker's Compensation/Government Programs.** The order of primary responsibility stated above shall not apply when the Member is entitled to receive health care services or indemnity benefits (a) under Worker's Compensation or similar law, or (b) in a Hospital or facility owned or operated by any government agency. In such case, the primary responsibility shall rest with those persons or agencies having the obligation to provide the health care services or indemnity benefits under (a) or (b) above.

UnitedHealthcare Insurance Company of the River Valley

ATTACHMENT A

Contract Period - The period commencing on December 1, 2018 and ending November 30, 2019 , and each 12-month period thereafter unless otherwise terminated as provided in the Article titled "Termination".

Annual Enrollment Period, as used in this attachment, means the designated period during which those persons meeting the eligibility requirements of UnitedHealthcare may enroll in UnitedHealthcare.

Late Member, as used in this attachment, is any applicant for coverage who does not qualify for special enrollment, as defined in Article 2 of this Contract, or any applicant who did not join UnitedHealthcare when first eligible forcoverage.

Eligible individuals who do not elect UnitedHealthcare coverage during an Annual Enrollment Period are considered Late Members.

UnitedHealthcare Insurance Company of the River Valley

ATTACHMENT B

To participate under this Contract as a Subscriber, an individual must meet the requirements agreed to by the Group and UnitedHealthcare.

To participate under this Contract as an Eligible Dependent, an individual must be one of the following persons:

1) The subscriber's legal spouse.
2) The Subscriber's child who is under age 26. Coverage terminates on the last day of the month in which the child reaches age 26.
3) The Subscriber's unmarried child, regardless of age, who is all of the following:
    a) permanently and totally disabled, if the disability occurred while an Eligible Dependent as defined in 2) above;
    b) incapable of self-sustaining employment; and
    c) primarily dependent upon the Subscriber or other care providers for support.

The term "child" means a natural born or legally adopted child, a child who has been placed with the Subscriber for adoption, a stepchild who lives with the Subscriber, or a child who is under the Subscriber's legal guardianship pursuant to a valid order of a United States federal or state court, or a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court of administrative order, even if the child does not reside within the service area.

UnitedHealthcare may require that the Subscriber furnish proof that a child or other dependent meets the qualifications of a dependent.

UnitedHealthcare Insurance Company of the River Valley

ATTACHMENT C

Enrollees with a complaint or appeal may reach UnitedHealthcare at the following address and/or phone number:

UnitedHealthcare Insurance Company of the River Valley
Attention: Member Appeals Department
1300 River Drive, Suite 200
Moline, IL 61265

Telephone Number: 1-800-251-9504
TTD Number: 1- 800-884-4327

and

UnitedHealthcare Insurance Company of the River Valley
3800 Avenue of the Cities, Suite 200
Moline, Illinois 61265
(800) 747-1446
(800) 884-4327 TDD

To file a complaint with the South Carolina Department of Insurance, they can be reached at the following address:

South Carolina Department of Insurance

P.O. Box 100105

Columbia, SC 29202-3105

803-737-6180

or

800-768-3467

UnitedHealthcare Insurance Company of the River Valley
Attachment D - Schedule of Benefits

Please refer to your Provider Directory for listings of Participating Physicians, Hospitals, and other Providers.

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Deductible (Contract Period)		
Individual	$4,000	$10,000
Family	$8,000	$20,000
All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount. The In-Network Deductible and Out-of-Network Deductible are separate.		
Maximum Out-of-Pocket Expense (Contract Period) (includes Copayments, and Coinsurance, and Deductibles)		
Individual	$7,350	$15,000
Family	$14,700	$30,000
All individual Maximum Out-of-Pocket amounts will count toward the family Maximum Out-of-Pocket Expense, but an individual will not have to pay more than the individual Maximum Out-of-Pocket Expense. The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate. Pharmacy cost sharing applies towards the Maximum Out-of-Pocket.		
4th Quarter Deductible Carryover	Not Applicable	Not Applicable

No Annual or Lifetime Dollar Limits apply to Essential Health Benefits.

Your PPO Policy provides both In-Network and Out-of-Network benefits. Out-of-Network benefits may require prior authorization and a higher Copayment and/or Coinsurance than that for In-Network benefits.

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Preventive Care Services *("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)*		
Physical Exams/Well-Child Care	Covered at 100%	50% of Allowed Charge after Deductible
Immunizations	Covered at 100%	50% of Allowed Charge after Deductible
Laboratory and X-ray	Covered at 100%	50% of Allowed Charge after Deductible
Physician Office Services		
Office Visits for Members age 19 and over	100% after you pay a Copayment of $40 PCP/$80 Specialist per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
Office Visits for Members under the age of 19	100% after you pay a Copayment of $0 PCP/$80 Specialist per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
Office Surgery	100% after you pay a Copayment of $40 PCP/$80 Specialist per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
Allergy Testing	100% after you pay a Copayment of $40 PCP/$80 Specialist per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
Allergy Injections	80% of Allowed Charge. Deductible does not apply.	50% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Other Injections	80% of Allowed Charge. Deductible does not apply.	50% of Allowed Charge after Deductible
Maternity Physician Services	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Newborn Services		
Inpatient	*See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	
Outpatient	*See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	
Physician Services at a Facility other than the Office		
Home Visits	100% after you pay a Copayment of $40 PCP/$80 Specialist per visit. Deductible does not apply.	50% of Allowed Charge after Deductible
Inpatient Facility Visits	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility Visits	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Inpatient Surgery	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Surgery	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Emergency Services *(Follow-up care obtained in the emergency room is not covered.)*		
Emergency Room Physician	80% of Allowed Charge after Deductible	80% of Allowed Charge after Deductible
Emergency Room	80% of Allowed Charge for initial care only of a Medical Emergency after deductible. You must first pay a Per Occurrence Deductible of $350 per visit.	80% of Allowed Charge for initial care only of a Medical Emergency after deductible. You must first pay a Per Occurrence Deductible of $350 per visit.
	Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.	
Urgent Care Facility	100% after you pay a Copayment of $50 per visit . Deductible does not apply.	50% of Allowed Charge after Deductible
Ambulance Services	80% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.**	80% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.**
Laboratory, X-ray and Other Diagnostic Testing		
Outpatient	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office	100% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Major Diagnostics		
(MRI, MRA, CAT and PET Scans)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
	Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.	

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Chemotherapy, Radiation Therapy, Renal Dialysis Services		
Hospital (Outpatient)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office	80% of Allowed Charge. Deductible does not apply.	50% of Allowed Charge after Deductible
Facility Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Skilled Nursing Facility (2) - *(Member is limited to 100 days per Contract Period . The 100 In-Network and Out-of-Network days are combined.)*	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Medical Equipment *(Diabetic supplies do not count toward the Durable Medical Equipment benefit maximum.)*		
Durable Medical Equipment (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Prosthetic Devices (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Hearing Aid Devices (2) *(Plan pays a maximum benefit of $2,500 per Contract Period)*	80% of Allowed Charge after Deductible	Not covered
Gender Dysphoria	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*
Outpatient Rehabilitative Therapy *Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.*		
	100% after you pay a Copayment of $40 per visit . Deductible does not apply.	50% of Allowed Charge after Deductible
Habilitative Services		
Inpatient	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."*
Outpatient	100% after you pay a Copayment of $40 per visit . Deductible does not apply.	50% of Allowed Charge after Deductible
Home Health Services (2)	80% of Allowed Charge after Deductible	Not covered
Hospice Services (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Respite Care (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Organ and Tissue Transplants (2)	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility*	Not covered

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
	Services," or other applicable categories.	
Cornea Transplants	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	
Clinical Trials	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.	100% after you pay a Copayment of $10 per visit. Deductible does not apply.	Not covered
Mental Health Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $40 per visit . Deductible does not apply.	50% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Partial Hospitalization/ Intensive Outpatient Treatment	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $40 per visit . Deductible does not apply.	50% of Allowed Charge after Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $40 per visit . Deductible does not apply.	50% of Allowed Charge after Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Cleft Lip and Cleft Palate Services	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	

Coverage Limitations:

(1) For services from Non-Participating Providers, the Allowed Charge is defined in Article 1 of the Certificate of Coverage. The Member is responsible for paying any amounts exceeding the Allowed Charge for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.

The Allowed Charge for Covered Services rendered by a Non-Participating Provider in a Medical Emergency will be determined as described in Section 1.1.2 of the Certificate of Coverage. **As a result, the Member will be responsible for the difference between the Non-Participating Provider's Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.**

For both Inpatient Surgery and Outpatient Surgery, Covered Services provided by facility based Non-Participating Physicians in a Participating Hospital or facility will be paid at the In-Network cost sharing level, however the Allowed Charge will be determined as described in Section 1.1.3 of the Certificate of Coverage. **As a result, the Member will be responsible for the difference between the Non-Participating Physician s Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense. In order to obtain the highest level of benefits, the Member should confirm whether a Physician is a Participating Physician prior to obtaining Covered Services.**

(2) Services require Preauthorization. When a Member uses Participating Providers, the Participati ng Provider is responsible for obtaining Preauthorization. When a Member uses Non-Participating Providers, the Member is responsible for obtaining Preauthorization from UnitedHealthcare (or for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider). If the Member fails to obtain Preauthorization for Covered Services from Non-Participating Providers, the Member will pay a Penalty of an additional 10 percentage points in his or her Out-of-Network Coinsurance. The Penalty amount paid by the Member will not exceed $1,000, and it will not count toward the Deductible or Maximum Out-of-Pocket Expense.

Continuity of Care

If you are under the care of a Network provider for a "serious medical condition" and the Network provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the provider's attestation as described below, for continuation of Covered Health Services rendered by the terminated provider for the time period shown below. Copayments, Coinsurance, deductibles, or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

Treatment by the terminated provider may continue until the course of treatment is complete, not to exceed 90 days from the effective date of termination.

For the purposes of this section serious medical condition means a health condition or Illness, which requires medical attention, and where failure to provide the current course of treatment through the current provider would place the Covered Person's health in serious jeopardy, and includes cancer, acute myocardial infarction, and Pregnancy. Such attestation by the treating Physician must be made upon the request of the Covered Person and in a written form approved by the South Carolina Department of Insurance or prescribed through regulation, order, or bulletin.

We are responsible for determining if a Covered Person qualifies for continuation of care. Upon receipt of the Covered Person's request for continuation accompanied by the Physician's attestation on the prescribed form, we will notify the

Covered Person and the provider of the provider's termination date from the Network and the continuation of care provision as described in this section.

When multiple Covered Services are performed, the Copayment, Coinsurance, and/or Deductible applicable to each Covered Service will apply. For example, a laboratory and x-ray service separately charged by an independent laboratory outside of the Physician's office has a separate Copayment, Coinsurance and/or Deductible in addition to the Physician's office Copayment, Coinsurance or Deductible.

UnitedHealthcare Insurance Company of the River Valley
SUPPLEMENTAL BENEFITS RIDER TO CERTIFICATE OF COVERAGE UNDER GROUP HEALTH CONTRACT

MANIPULATIVE SERVICES RIDER

This rider is subject to all provisions of the Certificate of Coverage under Group Health Contract (Certificate of Coverage) not in conflict with the provisions of this rider. In the event of such a conflict, the provisions in this rider shall govern coverage for manipulative services benefits.

Benefits will be payable for Members for manipulative services provided by a Participating Provider who is licensed to provide such care and who has entered into an agreement with OptumHealth Care Solutions, Inc. to provide manipulative services for UnitedHealthcare. Services are subject to preauthorization by OptumHealth Care Solutions, Inc.

Benefits payable under this supplemental rider do not apply toward any Outpatient Rehabilitative Therapy limits as defined in Attachment D of the Certificate of Coverage. Benefits payable under this rider are not subject to Deductibles, and Copayments do apply toward the Maximum Out-of- Pocket Expense as shown in Attachment D of the Certificate of Coverage.

The following services are covered by UnitedHealthcare subject to a $40 Copayment per visit.

Covered Spinal Manipulation Services

- Diathermy
- Electric Stimulation
- Emergency Room
- Massage
- Medical Supplies
- Office Visits
- Diagnostic Evaluation and X-ray services for the purpose of diagnosing the appropriateness of treatment under this rider.
- Spinal Manipulation
- Traction
- Ultrasound

The following services are not payable under this rider:

Acupressure • Acupuncture • Arch Supports • Biosoterometric Studies • Cervical Pillow • Chelation Therapy • Colonic Therapy or Irrigations • Computerized Axial Tomography • Durable Medical Equipment • Graphic X-ray Analysis • Hair Analysis • Hand Held Doppler • Heavy Metal Screening • Iridology • Iris Analysis • Kinesiology • Living Cell Analysis • Magnetic Resonance Imaging • Maintenance Care • Mineral Cellular Analysis • Moire Contourographic Analysis • Nutritional Counseling • Nutritional Supplements • Over-the-Counter Drugs or Preparations • Oxygen Therapy • Ream's Lab or Ream's Test • Rolfing • Sublingual or Oral Therapy • Thermographic Procedures • Toxic Metal Analysis.

Clinical Trials Amendment

UnitedHealthcare Insurance Company of the River Valley

As described in this Amendment, the Group Health Contract is modified as stated below. This Amendment is applicable to Group Health Contract issued in the state of South Carolina.

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

Any provision of this Amendment which is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Amendment is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

1. Clinical Trials

Benefits for routine patient care costs incurred by a Member when participating in a qualifying clinical trial are required under *the Patient Protection and Affordable Care Act (PPACA).* The benefit for *Clinical Trials* and the definition of Experimental or Investigational Service(s) in the *Certificate of Coverage (Certificate)* are replaced/added as described below:

Clinical Trials

Routine patient care costs incurred during participation 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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Member is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

- A service that is clearly inconsistent with 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 enrolled 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 that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or 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 that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which 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* as long as the study or investigation has been reviewed and approved through a system of peer review that 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 is conducted 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 and have been approved by all relevant institutional review boards *(IRBs)* before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Service and is not otherwise excluded under the Group Health Contract.

The definition of Experimental or Investigational Service(s) is added:

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

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

Exceptions:

- Clinical trials for which benefits are available as described under *Clinical Trials*
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* and have a sickness or condition that is likely to cause death within one year of the request for treatment we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Service for that sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

Robert Broomfield, President

Pediatric Dental Benefits

See the full description of these Benefits in the Pediatric Dental Services Rider.

Pediatric Vision Benefits

See the full description of these Benefits in the Pediatric Vision Care Services Rider.

First Page of the Certificate of Coverage

On the first page of the Certificate, the two paragraphs of text are deleted and replaced with the following text:

This Contract between the Subscriber who has enrolled and UnitedHealthcare Insurance Company of the River Valley ("UnitedHealthcare") is part of the Group Health Contract between UnitedHealthcare and Group through which the Member has enrolled. The Group Health Contract and this Contract, as defined in Article 1, form the entire contract.

This Contract entitles the Subscriber and Eligible Dependents to receive the benefits set forth herein during the Contract Period , subject to the terms and conditions of this Contract and upon payment of the Premium.

Your PPO Policy provides both Network and Non-Network benefits. Non-Network benefits may require prior authorization and a higher Copayment and/or Coinsurance than that for Network benefits.

No Annual or Lifetime Dollar Limits apply to Essential Health Benefits.

Robert Broomfield, President

Pediatric Dental Services Rider

UnitedHealthcare Insurance Company of the River Valley

This Rider to the Group Health Contract is issued to the Group and provides benefits for Covered Dental Services, as described below, for Members under the age of 19. Benefits under this Rider terminate on the last day of the month the Member reaches the age of 19.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 1: Definitions* or in this Rider in *Section 5: Defined Terms for Pediatric Dental Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of the River Valley . When we use the words "you" and "your", we are referring to people who are Members, as the term is defined in the *Certificate* in *Section 1: Definitions.*

Robert Broomfield, President

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

Network Benefits - these benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from an Out-of-Network 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 in excess of the contracted fee.

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

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers.* You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Out-of-Network Benefits - these benefits apply when you decide to obtain Covered Dental Services from Out-of-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an Out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay an Out-of-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from Out-of-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

What Are Covered Dental Services?

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

Benefits are available only for Necessary Dental 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 Rider.

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 Group Health Contract. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned 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.

Does Pre-Authorization Apply?

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental 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 assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Services exclusions* of this Rider.

Network 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 Services and benefits will not be payable.

Out-of-Network Benefits:

Benefits for Allowed Dental Amounts from out-of-Network providers are determined as a percentage of the Usual and Customary fees. You must pay the amount by which the Out-of-Network provider's billed charge exceeds the Eligible Dental Expense.

Deductible

Benefits for pediatric Dental Services provided under this Rider are subject to the Deductible stated in the Schedule of Benefits.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits.*

Benefits

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

Benefit limits are calculated on a Contract Period basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
Diagnostic Services *- (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. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D0150 - Comprehensive oral evaluation D0180 - Comprehensive periodontal evaluation *The following service is not subject to a frequency limit.* D0160 - Detailed and extensive oral evaluation - problem focused	0%	20%
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Complete series (including bitewings)	0%	20%
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0240 - Intraoral - occlusal film	0%	20%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings	0%	20%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image	0%	20%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0470 - Diagnostic casts	0%	20%
Preventive Services *- (Subject to payment of the Annual Deductible.)*		
Dental Prophylaxis (Cleanings) The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	0%	20%
Fluoride Treatments The following services are limited to two times every 12 months. D1206 and D1208 - Fluoride	0%	20%
Sealants (Protective Coating) The following services are Limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	0%	20%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral D1515 - Space maintainer - fixed - bilateral D1520 - Space maintainer - removable - unila D1550 - Re-cementation of space maintainerteral D1525 Space maintainer - removable bilateral	0%	20%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
Minor Restorative Services *- (Subject to payment of the Annual Deductible.)*		
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit.* D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	20%	40%
Composite Resin Restorations (Tooth Colored Fillings) *The following services are not subject to a frequency limit.* D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resign-based composite - four or more surfaces or involving incised angle, anterior	20%	40%
Crowns/Inlays/Onlays *- (Subject to payment of the Annual Deductible.)*		
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four surfaces D2740 - Crown - porcelain/ceramic substrate D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2780 - Crown - 3/4 case high noble metal	40%	50%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 Crown - titanium D2930 Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth *The following services are not subject to a frequency limit.* D2510 Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement inlay D2920 - Re-cement crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	40%	50%
The following service is limited to one time per tooth every 60 months. D2950 - Core buildup, including any pins	40%	50%
The following service is limited to one time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to Crown	40%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	40%	50%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
The following service is not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure	40%	50%
Endodontics *- (Subject to payment of the Annual Deductible.)*		
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration)	20%	40%
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development	20%	40%
The following service is not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior. primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	20%	40%
The following service is not subject to a frequency limit. D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy bicuspid D3348 - Retreatment of previous root canal therapy molar	20%	40%
The following service is not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification	20%	40%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
interim medication replacement D3353 - Apexification/recalcification final visit		
The following service is not subject to a frequency limit. D3354 - Pulpal Regeneration	20%	40%
The following service is not subject to a frequency limit. D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root	20%	40%
The following service is not subject to a frequency limit. D3450 - Root amputation - Per root	20%	40%
The following service is not subject to a frequency limit. D3920 - Hemisection (including any root removal), not including Root Canal Therapy	20%	40%
Periodontics *- (Subject to payment of the Annual Deductible.)*		
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three teeth	20%	40%
The following service is limited to one every 36 months. D4240 - Gingival flap Procedure, four or more teeth	20%	40%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
The following service is not subject to a frequency limit. D4249 - Clinical crown lengthening - hard tissue	20%	40%
The following service is limited to one every 36 months. D4260 - Osseous surgery	20%	40%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue Graft Procedure D4271 - Free soft tissue graft procedure	20%	40%
The following service is not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth	20%	40%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant	20%	40%
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	20%	40%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	20%	40%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
Removable Dentures *- (Subject to payment of the Annual Deductible.)*		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base D5212 - Maxillary partial denture - resin base D5213 - Maxillary partial denture - cast metal framework with resin denture base D5214 - Mandibular partial denture - cast metal framework D5281 - Removable unilateral partial denture - one piece cast metal	40%	50%
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5510 - Repair broken complete denture base D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5620 - Repair cast framework D5630 - Repair or replace broken clasp D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture	40%	50%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
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. D5710 - Rebase complete maxillary denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5730 - Reline complete maxillary denture D5731 - Reline complete mandibular denture D5740 - Reline maxillary partial denture D5750 - Reline complete maxillary denture (laboratory)	40%	50%
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	40%	50%
Bridges (Fixed partial dentures) *- (Subject to payment of the Annual Deductible.)*		
The following services are not subject to a frequency limit. D6210 - Pontic - case high noble metal D6211 - Pontic - case predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6245 - Pontic - porcelain/ceramic	40%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for	40%	50%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis		
The following services are not subject to a frequency limit. D6519 - Inlay/onlay - porcelain/ceramic D6520 - Inlay - metallic - two surfaces D6530 - Inlay - metallic - three or more surfaces D6543 - Onlay - metallic - three surfaces D6544 - Onlay - metallic - four or more surfaces	40%	50%
The following services are limited to one time every 60 months. D6740 - Crown - porcelain/ceramic D6750 - Crown - porcelain fused to high noble metal D6751 - Crown - porcelain fused to predominately base metal D6752 - Crown - porcelain fused to noble metal D6780 - Crown - 3/4 cast high noble metal D6781 - Crown - 3/4 cast predominately base metal D6782 - Crown - 3/4 cast noble metal D6783 - Crown - 3/4 porcelain/ceramic D6790 - Crown - full cast high noble metal D6791 - Crown - full cast predominately base metal D6792 - Crown - full cast noble metal	40%	50%
The following service is not subject to a frequency limit. D6930 - Re-cement or Re-bond Fixed Partial Denture	40%	50%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
The following services are not subject to a frequency limit. D6973 - Core build up for retainer, including any pins D6980 - Fixed partial denture repair necessitated by restorative material failure	40%	50%
Oral Surgery *- (Subject to payment of the Annual Deductible.)*		
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root	20%	40%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring elevation of mucoperioteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - complete bony with unusual surgical D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal	20%	40%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	20%	40%
The following service is not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth	20%	40%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant D7311 - Alveoloplasty in conjunction with extraction one to three teeth or tooth space - per quadrant D7320 - Alveoloplasty not in conjunction with extractions per quadrant D7321 - Alveoloplasty not in conjunction with extractions one to three teeth or tooth space - per quadrant	20%	40%
The following service is not subject to a frequency limit. D7471 - removal of lateral exostosis (maxilla or mandible)	20%	40%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess D7910 - Suture of recent small wounds up to 5 cm D7971 - Excision of pericoronal gingiva	20%	40%
Adjunctive Services *- (Subject to payment of the Annual Deductible.)*		
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. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure	20%	40%
Covered only when clinically Necessary. D9220 - Deep sedation/general anesthesia first 30 minutes, including nitrous oxide	20%	40%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
D9221 - Dental sedation/general anesthesia each additional 15 minutes D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9610 - Therapeutic drug injection, by report		
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	20%	40%
The following is limited to one guard every 12 months. D9940 - Occlusal guard	20%	40%
Implant Procedures *- (Subject to payment of the Annual Deductible.)*		
The following services are limited to one time every 60 months. D6010 - Endosteal implant D6012 - Surgical placement of interim implant body D6040 - Eposteal Implant D6050 - Transosteal implant, including hardware D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported		

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
D6056 - Prefabricated abutment D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to high noble metal D6060 - Abutment supported porcelain fused to predominately base metal crown D6061 - Abutment supported porcelain fused to noble metal crown D6062 - Abutment supported cast high noble metal crown D6063 - Abutment supported case predominately base metal crown D6064 - Abutment supported porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported porcelain fused to high metal crown D6067 - Implant supported metal crown D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture. D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture. D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture. D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture	40%	50%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
D6072 - Abutment supported retainer for cast high noble metal fixed partial denture D6073 - Abutment supported retainer for predominately base metal fixed partial denture D6074 - Abutment supported retainer for cast metal fixed partial denture D6075 - Implant supported retainer for ceramic fixed partial denture D6076 - Implant supported retainer for porcelain fused to high noble metal fixed partial denture D6077 - Implant supported retainer for cast metal fixed partial denture D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch D6080 - Implant maintenance procedure D6090 - Repair implant prosthesis D6091 - Replacement of semi-precision or precision attachment D6095 - Repair implant abutment D6100 - Implant removal D6190 - Implant index		
Medically Necessary Orthodontics *- (Subject to payment of the Annual Deductible.)*		
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, *Crouzon's syndrome, Treacher-Coll ins Syndrome, Pierre-Robin Syndrome,* hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical		

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
(overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodonti c treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8050 - Interceptive orthodontic treatment of the primary dentition D8060 - Interceptive orthodontic treatment of the transitional dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic	40%	50%

Benefit Description and Limitations	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
treatment visit D8680 - Orthodontic retention		

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Covered Dental Services,* benefits are not provided under this Rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Covered Dental Services.*
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. 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.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. 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.
12. 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.
13. 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.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Member becoming enrolled for coverage provided through this Rider to the Group Health Contract.

16. Dental Services otherwise covered under the Group Health Contract, but rendered after the date individual coverage under the Group Health Contract terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Group Health Contract terminates.
17. Services rendered by a provider with the same legal residence as a Member or who is a member of a Member's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from an out-of-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* under *Claim Provisions* apply to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Member's name and address.
- Member's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in *Section 1: Definitions* of the *Certificate:*

Covered Dental Service - a Dental Service or Dental Procedure for which benefits are provided under this Rider.

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

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Member while the Group Health Contract 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.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Group Health Contract is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-Network Benefits, when Covered Dental Services are received from Out-of-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary fees, as defined below.

Necessary - Dental Services and supplies under this Rider 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 Member.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental 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 Member 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 Service as defined in this Rider. The definition of Necessary used in this Rider relates only to benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual and Customary - Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association).*

- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that we accept.

Pediatric Vision Care Services Rider

UnitedHealthcare Insurance Company of the River Valley

How Do You Use This Document?

This Rider to the Group Health Contract is issued to the Group and provides benefits for Vision Care Services, as described below, for Members under the age of 19. Benefits under this Rider terminate on the last day of the month the Member reaches the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate) in Section 1: Definitions* or in this Rider in *Section 4: Defined Terms for Pediatric Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of the River Valley. When we use the words "you" and "your" we are referring to people who are Members, as the term is defined in the *Certificate* in *Section 1: Definitions.*

Robert Broomfield, President

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or Out-of-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the *Certificate in Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Vision Care Services.* Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you will be required to pay any Co-payments at the time of service.

Network Benefits:

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.

Out-of-Network Benefits:

Benefits for Vision Care Services from out-of-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Co-insurance for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits.* Any amount you pay in Co-payments for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedul e of Benefits.*

Deductible

Benefits for pediatric Vision Care Services provided under this Rider are subject to any Deductible stated in the Schedule of Benefits. Any amount you pay in Co-payments for Vision Care Services under this Rider does not apply to the Deductible stated in the *Schedule of Benefits.*

What Are the Benefit Descriptions?

Benefits

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

Benefit limits are calculated on a Contract Period 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-payments and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).

- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing - far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination 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 mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

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

If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Co-payment will apply to those Eyeglass Lenses and Eyeglass Frames together.

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 select only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If you select more than one of these Vision Care Services, we will pay benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Contact Lenses

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

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If you select 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 examination of visual functions; and
  - The prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Out-of-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam	Once every 12 months.	$10 per exam. Not subject to payment of the Annual Deductible.	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Out-of-Network Benefit
Eyeglass Lenses	Once every 12 months.		
• *Single Vision*		$25 per pair of eyeglass lenses. Not subject to payment of the Annual Deductible.	50% of the billed charge.
• *Bifocal*		$25 per pair of eyeglass lenses. Not subject to payment of the Annual Deductible.	50% of the billed charge.
• *Trifocal*		$25 per pair of eyeglass lenses. Not subject to payment of the Annual Deductible.	50% of the billed charge.
• *Lenticular*		$25 per pair of eyeglass lenses. Not subject to payment of the Annual Deductible.	50% of the billed charge.
Lens Extras			
Polycarbonate lenses	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None
Standard scratch-resistant coating	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None

Eyeglass Lenses	Once every 12 months.		
• Eyeglass frames with a retail cost up to $130.		0% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - 160.		$15 per eyeglass frame. Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - 200.		$30 per eyeglass frame. Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		$50 per eyeglass frame. Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		40% Not subject to payment of the Annual Deductible.	50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None
• *Covered Contact Lens Selection*	Limited to a 12 month supply.	$25 per supply of contact lenses. Not subject to payment of the Annual Deductible.	50% of the billed charge.

• *Necessary Contact Lenses*	Limited to a 12 month supply.	$25 per supply of contact lenses. Not subject to payment of the Annual Deductible.	50% of the billed charge.
Low Vision Services Note that Benefits for these services will paid as reimbursements. When obtaining these Vision 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 limited to the amounts stated.	Once every 24 months.		
• Low vision testing		0%	25% of billed charges
• Low vision therapy		25%	25% of billed charges

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Pediatric Vision Care Services,* benefits are not provided under this Rider 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 *Certificate.*
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services.*
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, 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 in the *Certificate* in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by an out-of-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or an out-of-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

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

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 1: Definitions* of the *Certificate:*

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

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which benefits are available under the Group Health Contract.

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 this Rider in *Section 1: Benefits for Pediatric Vision Care Services.*

Health Resources and Services Administration (HRSA) Amendment

UnitedHealthcare Insurance Company of the River Valley

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

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

Because this Amendment is part of a legal document (the Group Health Contract), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Artice 1: Definitions*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of the River Valley . When we use the words "you" and "your", we are referring to people who are Subscribers, as that term is defined in *Article I: Definitions.*

Benefits for Breast Pumps

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Network benefits for preventive care are payable at 100% of Allowed Charges (without application of any Copayment, Coinsurance, or Deductible).

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Robert Broomfield, President

UnitedHealthcare Insurance Company of the River Valley
Real Appeal Rider

This Rider to the Group Health Contract provides benefits for virtual obesity counseling services for eligible Members through Real Appeal. There are no Deductibles, Copayments or Coinsurance the Members must meet or pay for when receiving these services.

Real Appeal

Benefits are provided for Real Appeal, which provides a virtual lifestyle intervention for weight-related conditions to eligible Members. The goal is to help those at risk from obesity-related diseases. Real Appeal is designed to support Members over the age of 18.

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

These Covered Services will be individualized and may include, but are not limited to, the following:

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

Members wanting additional information regarding these Covered Services, please call Real Appeal at 1-844-344 REAL (1-844-344-7325). TTY users can dial 711 or visit www.realappeal.com.

Robert Broomfield, President

Member Bill of Rights and Responsibilities

As a member of UnitedHealthcare Insurance Company of the River Valley , you have certain rights and responsibilities, which are outlined below.

MEMBER BILL OF RIGHTS

Members have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel and network physicians and providers.
- Privacy and confidentiality for treatments, tests or procedures you receive.
- Voice concerns about the service and care you receive.
- To register complaints and appeals concerning your health plan or the care provided to you.
- Receive timely responses to your concerns.
- Participate in a candid discussion with your physician about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Be provided with access to health care, physicians and other health care professionals.
- Participate with your physician and other caregivers in decision about your care.
- Make recommendations regarding the organization's member's rights and responsibilities policies.
- Receive information about UnitedHealthcare, our services and network physicians and other health care professionals.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards.
- Choose an Advance Directive to designate the kind of care you wish to receive should you be unable to express your wishes.

MEMBERS' RESPONSIBILITIES

Members are responsible for:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow agreed-upon instructions and guidelines of physicians and health care professionals.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals.
- Notify your employer's human resource department of changes in address or family status.
- Visit our Web site **www.myuhc.com**, or call customer service when you have a question about your eligibility, benefits, claims and more.
- Access our Web site **www.myuhc.com** or call customer service to verify that your physician or health care professional is participating in the UnitedHealthcare Insurance Company of the River Valley network before receiving services.

Advance Medical Directives

UnitedHealthcare Insurance Company of the River Valley has been instructed by federal law to inform you about your rights under The Patient Self-Determination Act.

What happens if you become too sick to make your own decisions regarding your medical care? Your family and doctor must decide what treatment to use, when not to treat, and when to stop treatment. Sometimes they don't know what you would want, or aren't able to agree on what would be best for you. It is much better if they are sure of what you want and who you want to make these decisions.

With the enactment of a federal law, The Patient Self-Determination Act, you have the right to make decisions about your future health care. This includes the right to accept or refuse medical or surgical treatment and to plan and direct the types of health care you may receive if you become unable to express your wishes. You can exercise this right by making an Advance Medical Directive.

UnitedHealthcare Insurance Company of the River Valley supports your rights under this law. However, coverage of your medical care by UnitedHealthcare Insurance Company of the River Valley is in no way influenced by your having an Advance Medical Directive.

UnitedHealthcare Insurance Company of the River Valley participating providers have, in accordance with state law, varying practices regarding the implementation of an advance directive. Such practices must be made available to you when selecting or receiving care from the provider.

For example, if your physician, as a matter of conscience, is unable to comply with your directives, they must take all reasonable steps to arrange to transfer you to another physician.

What is an Advance Directive?

An advance directive explains, in writing, your choices about the treatment you want or do not want, or about how health care decisions will be made for you if you are too ill to express your wishes.

An advance directive expresses your personal wishes and is based upon your beliefs and values. When you make an advance directive, you will consider issues like dying, living as long as possible, being kept alive on machines, being independent, and the quality of your life.

Use of an Advance Medical Directive makes it possible for your wishes to be carried out during a serious illness.

If you are an adult and of "sound mind," you can make an advance directive.

There are two types of formal advance directives. You can complete either a Living Will, a Power of Attorney for Health Care, or both.

Living Will

A Living Will informs your physician that you want to die naturally if you develop an illness or injury that cannot be cured. It tells your physician that, when you are near death or in a vegetative state, he or she should not use life-prolonging measures which postpone, but do not prevent, death.

A Living Will allows you to refuse treatments or machines which keep your heart, lungs or kidneys functioning when they are unable to function on their own.

The Power of Attorney for Health Care

The Power of Attorney for Health Care is a form in which you appoint another person (a "health care agent") to make health care decisions for you if you are not capable of making them yourself.

Maintaining Your Advance Directive

You should keep your advance directive in a safe place where you and others can easily find it. (Do not keep it in a safe deposit box.) You should make sure your family members and your lawyer, if you have one, know you have made an advance directive and know where it is located. Be sure your Plan physician has a copy of your directive in your medical file.

Most states have specific rules as to what will be recognized as a valid advance directive. Forms are available through your state's Medical Society or Bar Association. Follow the instructions provided by your state when completing the advance directives forms.

Will All States Recognize My Directives?

If you plan to spend time in a state other than your state of residence, from which you obtained your Advance Medical Directives, you may wish to execute advance directives in compliance with that state's laws as well.

Specific questions should be directed to your physician and/or attorney for guidance.

UnitedHealthcare Insurance Company of the River Valley

SUPPLEMENTAL BENEFITS RIDER TO CERTIFICATE OF COVERAGE UNDER GROUP HEALTH CONTRACT

PRESCRIPTION DRUG PRODUCTS

This Prescription Drug Product Rider (Drug Rider) is subject to all provisions of the Certificate of Coverage under Group Health Contract (Certificate of Coverage) not in conflict with the provisions of this Drug Rider. In the event of such conflict, the provisions in this Drug Rider will govern coverage for Prescription Drug Products.

INTRODUCTION

COVERAGE POLICIES AND GUIDELINES

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

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

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

A specific tier is not limited to certain classes or categories of Prescription Drug Products. Tier 1 represents the lowest cost option for the Member. For the lowest out-of-pocket expense, consider Tier 1 medications. Tier 2 represents a middle cost option for the Member. In both cases, consider Tier 1 or 2 medications if the Member and the prescribing Physician decide Tier 1 or 2 medications are right for the Member's treatment. Prescription Drug Products placed in a higher tier have a greater cost option to you the Member; also note that Prescription Drug Products in higher tiers generally have an available Tier 1 or 2 alternative.

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

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

SPECIALTY DESIGNATED PHARMACIES

If the Member requires certain Prescription Drug Products, UnitedHealthcare may direct the Member to a Specialty Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Prescription Drug Products. If the Member chooses not to obtain their Prescription Drug Product from the Specialty Designated Pharmacy, the Member may opt-out of the Specialty Designated Pharmacy program through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card. If the Member wants to opt-out of the program and fill their Prescription Drug Product at a non-Specialty Designated

Pharmacy but does not inform us, the Member will be responsible for the entire cost of the Prescription Drug Product and no benefits will be paid.

If the Member is directed to a Specialty Designated Pharmacy and the Member informs UnitedHealthcare of their decision not to obtain his or her Prescription Drug Product from a Specialty Designated Pharmacy, the Member will be subject to the non-Network benefit for that Prescription Drug Product, or, for a Specialty Prescription Drug Product, if the Member chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Member will be subject to the Non-Preferred Specialty Network Copayment and/or Coinsurance.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Specialty Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Member will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Specialty Designated Pharmacy will contact the Member each time prior to dispensing the 15-day supply to confirm if the Member is tolerating the Specialty Prescription Drug Product. The Member may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, through the internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

Smart Fill Program - 90 Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Specialty Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The Smart Fill Program which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Member who is stabilized on a Specialty Prescription Drug Product included in the Smart Fill Program. The Member may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, through the internet www.myuhc.co m or by calling Customer Service at the telephone number on his or her ID card.

LIMITATION ON SELECTION OF PHARMACIES

If UnitedHealthcare determines that the Member may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, his or her selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require the Member to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Member uses the designated single Network Pharmacy. If the Member doesn't make a selection within thirty-one (31) days of the date UnitedHealthcare notifies the Member, UnitedHealthcare will select a single Network Pharmacy for the Member.

REBATES AND OTHER PAYMENTS

UnitedHealthcare may receive rebates for certain drugs included on the Prescription Drug List. UnitedHealthcare does not pass these rebates on to the Member, nor are they taken into account in determining his or her Drug Copayments and/or Drug Coinsurance. UnitedHealthcare, and a number of UnitedHealthcare's affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Drug Rider. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Drug Rider. UnitedHealthcare is not required to pass on to the Member, and does not pass on to the Member, such amounts.

COUPONS, INCENTIVES AND OTHER COMMUNICATIONS

At various times, UnitedHealthcare may send mailings to the Member or his or her Attending Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable the Member, at his or her discretion, to purchase the described Prescription Drug Product at a discount or to obtain it at no charge. In some instances, non-UnitedHealthcare entities may support and/or provide the content for these mailings. Only the Member's physician can determine whether a change in his or her Prescription Order or Prescription Refill is appropriate for his or her medical condition.

SPECIAL PROGRAMS

UnitedHealthcare may have certain programs in which the Member may receive an enhanced or reduced benefit based on his or her actions, such as adherence/compliance to medication regimens. The Member may access

information on these programs through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

Maintenance Medication Program If the Member requires certain Maintenance Medications, UnitedHealthcare may direct the Member to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If the Member chooses not to obtain their Maintenance Medications from the Mail Order Network Pharmacy or referred 90 Day Retail Network Pharmacy, the Member may opt-out of the Maintenance Medication Program through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card. If the Member chooses to opt out of Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but does not inform UnitedHealthcare, the Member will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at retail Network Pharmacy.

SPECIALTY PRESCRIPTION DRUG PRODUCTS

Benefits are provided for Specialty Prescription Drug Products.

If the Member requires Specialty Prescription Drug Products, UnitedHealthcare may direct him or her to a Specialty Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products.

If the Member is directed to a Specialty Designated Pharmacy and the Member has informed UnitedHealthcare of their decision not to obtain his or her Specialty Prescription Drug Product from a Specialty Designated Pharmacy, the Member will be subject to the non-network Copayment and/or Coinsurance for that Specialty Prescription Drug Product.

Please see *Definitions* for a full description of Specialty Prescription Drug Products and Specialty Designated Pharmacy.

Specialty Prescription Drug Products - The following supply limits apply.

> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
>
> When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Drug Copayment and/or Drug Coinsurance that applies will reflect the number of days dispensed.
>
> Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty, a Non-Network Pharmacy, a mail order Network Pharmacy, or Designated Pharmacy.

COORDINATION OF BENEFITS

Coordination of Benefits applies to Prescription Drug Products covered through this Drug Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as benefits for other health services, as described in the Member's Certificate of Coverage.

DEFINITIONS

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

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

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

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

- The Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price for outof-Network Pharmacies for the Prescription Drug Product.

The Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

Brand-Name Drug - a Prescription Drug Product: (1) that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a brand-name product, based on available data resources including, but not limited to, Medi Span that classify drugs as either brand or generic based on a number of factors. The Member should know that all Prescription Drug Products identified as "brand name" by the manufacturer, pharmacy, or the Member's physician may not be classified as Brand-Name Drugs by UnitedHealthcare.

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

Co-Marketed Drug - equivalent Brand-Name Drug that contains the same active ingredient(s) and is available from more than one pharmaceutical company.

Compounded Prescription - a Prescription Drug Product that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the FDA and that contains at least one ingredient classified as a Prescription Drug Product.

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

Direct Member Reimbursement - the process whereby a Member pays for a Prescription Drug Product at a pharmacy and submits a receipt and claim form to UnitedHealthcare for reimbursement based on the Predominant Reimbursement Rate.

Drug Copayment - the amount the Member must pay for each Prescription Drug Product received. Each Drug Copayment shall be paid at the time the service is rendered.

Generic Drug - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-Name Drug; or (2) that UnitedHealthcare identifies as a generic drug product based on available data resources, including, but not limited to First DataBank, that classify drugs as either brand or Generic Drug based on a number of factors. The Member should know that all Prescription Drug Products identified as a "generic drug" by the manufacturer, pharmacy, or his or her physician may not be classified as a Generic Drug by UnitedHealthcare.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. The Member may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

Maximum Allowable Cost (MAC) List - a list of Generic Drugs that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare's periodic review and modification.

Network Pharmacy - a licensed pharmacy that has entered into a contractual agreement with UnitedHealthcare to dispense Prescription Drug Products to Members.

Non-Network Pharmacy - any licensed pharmacy that has not entered into a contractual arrangement with UnitedHealthcare to dispense Prescription Drug Products to Members.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that UnitedHealthcare identifies as a non-preferred pharmacy within the network.

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

Pharmacy Billed Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Pharmacy Billed Charge includes a dispensing fee and any applicable sales tax.

Predominant Reimbursement Rate - the amount UnitedHealthcare will pay to reimburse the Member for a Prescription Drug Product that is dispensed at a Non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a Non-Network Pharmacy includes a dispensing fee and any applicable sales tax. UnitedHealthcare calculates the Predominant Reimbursement Rate using UnitedHealthcare's Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Preferred Specialty Network Pharmacy - a specialty pharmacy that UnitedHealthcare identifies as a preferred pharmacy within the network.

Prescription Drug Cost - the rate UnitedHealthcare has agreed to pay UnitedHealthcare's Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the FDA. This list is subject to UnitedHealthcare's periodic review and modificati on. These changes will occur no more than six (6) times per calendar year. The Member may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

Prescription Drug List Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product(s) - a medication product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Prescription Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under this Drug Rider, this definition includes:

Inhalers (with spacers);

Insulin;

The following diabetic supplies:

Standard insulin syringes with needles;

Blood-testing strips - glucose;

Urine-testing strips - glucose;

Ketone-testing strips and tablets;

Lancets and lancet devices;

Glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your Certificate of Coverage.

Prescription Fill - the initial quantity of a Prescription Drug Product dispensed pursuant to a Prescription Order.

Prescription Order - authorization for the dispensing of a Prescription Drug Product, issued by an Attending Physician who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Prescription Refill - a subsequent quantity of a Prescription Drug Product dispensed after the initial Prescription Fill.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

90-Day Supply List - a listing of Prescription Drug Products that UnitedHealthcare has approved for coverage when obtained in quantities up to a 90-day supply. This list will be subject to periodic review and modification by UnitedHealthcare.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. The Member may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

COVERED DRUGS

To be covered under this Drug Rider, Prescription Drug Products must not be otherwise excluded in this Drug Rider or in the Certificate of Coverage.

Prescription Drug Products will be covered only for FDA-approved indications or for non-FDA-approved indications if such use is commonly accepted as a standard of care, as indicated by the following official compendia:

The AMA Drug Evaluations, The American Hospital Formulary Service Drug Information, or The United States Pharmacopoeia Dispensing Information.

DRUG COPAYMENTS

Drug Copayment for a Prescription Drug Product at a Network or Non-Network Pharmacy is a specific dollar amount.

Coupons: UnitedHealthcare may not permit the Member to use certain coupons or offers from pharmaceutical manufacturers to reduce the Member's Copayment and/or Coinsurance. The Member may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

The Member's Drug Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product.

For Prescription Drug Products at a retail Network Pharmacy, the Member is responsible for paying the lowest of the following:

- The applicable Co-payment and/or Co-insurance.
- The Network Pharmacy's Pharmacy Billed Charges for the Prescription Drug Product; or.
- The Prescription Drug Charge for that Prescription Drug Product

For Prescription Drug Products from a mail order Network Pharmacy, the Member is responsible for paying the lower of:

- The applicable Drug Copayment ; or
- The Prescription Drug Cost for that Prescription Drug Product;

Prescription Drug Products are subject to the following cost-sharing schedule:

Tier 1 $15 Drug Copayment in addition to any Ancillary Charge applies.

Tier 2 $50 Drug Copayment in addition to any Ancillary Charge.

Tier 3 $75 Drug Copayment in addition to any Ancillary Charge.

Tier 4 $125 Drug Copayment applies in addition to any Ancillary Charge.

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

Drug Copayments, Ancillary Charges for Prescription Drug apply towards the applicable Maximum Out of Pocket Expense, as shown in Attachment D to the Certificate of Coverage.

Ancillary Charges.

Certain coupons or offers from pharmaceutical manufacturers. The Member may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual an Customary Charge for a Prescription Drug Product.

Any non-covered drug product. The Member is responsible for paying 100% of the cost (the amount the pharmacy charges the Member) for any non-covered drug product and UnitedHealthcare's contracted rates (UnitedHealthcare's Prescription Drug Cost) will not be available to the Member.

The Member's Drug Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product.

NOTE: The tier status of a Prescription Drug Product can change periodically based on the Prescription Drug List Management Committee's periodic tiering decisions. These changes will occur no more than six (6) times per calendar year. These changes may occur without prior notice to the Member. When that occurs, the Member may pay more or less for a Prescription Drug Product, depending on its tier assignment. The Member may access www.myuhc.com through the Internet or call Customer Service at the telephone number on his or her ID card for the most up-to-date tier status.

APPLICATION OF DRUG COPAYMENTS

The Member is responsible for one Drug Copayment for each 31-day supply or such other day supply as determined by UnitedHealthcare. Member may request up to a 90-day supply of Prescription Drug Products on the 90-Day Supply List. Member is responsible for two and a half Drug Copayment(s), for each 90-day supply Prescription Fill or Prescription Refill purchased at a retail pharmacy that has agreed to dispense a 90 day supply or by mail order.

If for any reason a Member utilizes a Non- Network Pharmacy to obtain a Prescription Drug Product, the Member will be required to pay the Pharmacy Billed Charge. The Member should contact UnitedHealthcare's Customer Service Department to obtain a Direct Member Reimbursement form. The Member must complete the form and submit it to UnitedHealthcare together with the pharmacy receipt to be considered for reimbursement. If UnitedHealthcare approves reimbursement, the Member will be responsible for the Drug Copayment plus the difference between the Pharmacy Billed Charge and UnitedHealthcare's Prescription Drug Cost.

IF A BRAND-NAME DRUG BECOMES AVAILABLE AS A GENERIC DRUG

If a Generic Drug becomes available for a Brand-Name Drug, the tier placement of the Brand-Name Drug may change, and therefore the Member's Drug Copayment may change and an Ancillary Charge may apply or the Member will no longer have benefits for that particular Brand-name Drug.

LIMITATIONS

Prescription quantity shall be limited to the amount ordered by the Attending Physician for a specified course of treatment. Quantity per Prescription Fill or Prescription Refill shall not exceed a 31-day supply or such other day supply as authorized by UnitedHealthcare. However, Prescription Drug Products on the 90-Day Supply List may be dispensed in quantities up to a maximum of 90-day supply through a retail pharmacy that has agreed to dispense a 90 day supply or by mail order.

These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products

from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.*

A Member will be considered to have an adequate supply of medication from the previous dispensing date and will not be eligible for benefits under this Drug Rider if an insufficient number of days have elapsed between Prescription Fills or Prescription Refills as determined by UnitedHealthcare.

For contraceptives a one-cycle supply is allowed. However, the Member may obtain up to three (3) cycles at one time if the Member pays a Drug Copayment and/or Drug Coinsurance for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Drug Copayment and/or Drug Coinsurance that applies will reflect the number of days dispensed.

UnitedHealthcare reserves the right to limit the quantity dispensed per Prescription Fill or Prescription Refill and the frequency of Prescription Fills or Prescription Refills to those reasonable for a specified condition or episode or usual dosing frequency approved by the FDA.

UnitedHealthcare reserves the right to establish criteria and require prior authorization for new or currently available Prescription Drug Products.

NOTIFICATION REQUIREMENTS

Before certain Prescription Drug Products are dispensed to the Member, either the Member's physician, the Member's pharmacist, or the Member is required to obtain prior authorization from UnitedHealthcare or UnitedHealthcare's designee. The reason for obtaining prior authorization from UnitedHealthcare is to determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of "Medically Necessary" as described in the Certificate of Coverage.
- It is not otherwise excluded as experimental and/or investigational, or for any other reason, in the Certificate of Coverage or this Drug Rider.

Network Pharmacy Prior Authorization

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

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Non-Network Pharmacy, the Member or his or her physician is responsible for obtaining prior authorization from UnitedHealthcare as required.

If prior authorization is not obtained from UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, the Member may pay more for that Prescription Order or Prescription Refill. The Prescription Drug Products requiring notification prior authorization are subject to UnitedHealthcare's periodic review and modification. There may be certain Prescription Drug Products that require the Member to notify UnitedHealthcare directly rather than the Memberbs Physician or Provider. The Member may determine whether a particular Prescription Drug Product requires notification prior authorization through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

If prior authorization is not obtained from UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, the Member can ask UnitedHealthcare to consider reimbursement after the Member receives the Prescription Drug Product. The Member will be required to pay for the Prescription Drug Product at the pharmacy. UnitedHealthcare's contracted pharmacy reimbursement rates (UnitedHealthcare's Prescription Drug Cost) will not be available to the Member at a non-Network Pharmacy. The Member may seek reimbursement from us as described in the section *Application of Drug Copayment.*

When the Member submits a claim on this basis, the Member may pay more because he or she did not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product was dispensed. The amount the Member is reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a Non-Network Pharmacy), less the required Drug Copayment and/or Drug Coinsurance, Ancillary Charge and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not covered.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. The Member may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on his or her ID card.

STEP THERAPY

Certain Prescription Drug Products for which benefits are described under this Drug Rider or Pharmaceutical Products for which Benefits are described in the Member's Certificate of Coverage are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products or Pharmaceutical Products the Member is required to use a different treatment(s) and/or Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

EXCLUSIONS

Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.

Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

Prescription Drug Products dispensed outside the United States, except as required for emergency treatment.

A Pharmaceutical Product for which benefits are provided in the Member's Certificate of Coverage. This includes all forms of vaccines and immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless UnitedHealthcare has designated the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that UnitedHealthcare has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a Contract Period , and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.

Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that UnitedHealthcare determines are excluded under the Certificate of Coverage.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare determines do not meet the definition of a Covered Health Service.

Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by UnitedHealthcare's PDL Management Committee.

Experimental, unproven or investigational medications, medications used for experimental indications, and/or dosage regimens determined by UnitedHealthcare to be experimental, investigational or unproven. This exclusion does not apply to a Prescription Drug Product used for the treatment of cancer which is not approved by the *U.S. Food and Drug Administration (FDA)* for the treatment of the specific type of cancer for which it has been prescribed if the Prescription Drug Product is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature as defined by state law.

Drugs which are prescribed, dispensed or intended for use during an inpatient stay.

Prescription Drug Products not included on Tier 1, Tier 2, Tier 3, or Tier 4 of the Prescription Drug List at the time the Prescription Order or Prescription Refill is dispensed.

Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Member's Certificate of Coverage. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

Drugs that are entirely consumed at the time and place of prescribing.

Drugs dispensed to a Member while an inpatient in a facility such as a hospital or similar institution when such institution dispenses and bills for medications used during confinement.

Medications dispensed by a facility other than a licensed pharmacy.

Charges for the administration or injection of any medication.

Injectable medications that are not typically self-administered by the Member. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Any type of therapeutic or prosthetic device, appliance, support, or hypodermic syringe (other than disposable syringes to inject insulin), even though such device, appliance, support, or syringe may require a prescription. Such items may be payable as Durable Medical Equipment as described in the Certificate of Coverage.

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

Prescription Drug Products furnished by the local, state, or federal government. Any Prescriptio n 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.

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.

Medications dispensed prior to the effective date or after the termination date of Member's coverage.

Medications that are abused or otherwise misused by the Member.

Medications prescribed for cosmetic purposes.

Medications used to enhance physical or mental performance (e.g., anabolic steroids) without a defined underlying pathological cause.

Prescription Drug Products in convenience packaging when the cost exceeds the cost of the drug when purchased in its normal container.

Unit dose packaging or repackagers of Prescription Drug Products. Unit dose packaging of Prescription Drug Products.

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 assigned to Tier 4.)

Growth promoting substances, unless medically necessary.

Any medication for treatment of sexual dysfunction or impotence, or to improve sexual performance or functioning.

Any product dispensed for the purpose of appetite suppression or weight loss.

Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of sickness or injury, except as required by state mandate.

Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.

Prescription Drug Products when prescribed as sleep aids

General vitamins, except the following, which require a Prescription Order or Prescription Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to

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

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

Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.

A Prescription Drug Product with an approved biosimilar or 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 showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.

Dental products, including but not limited to prescription fluoride topicals.

Diagnostic kits and products.

Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

A Prescription Drug Product that contains marijuana, including medical marijuana.

Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) in order to comply with essential health benefits requirements.

Treatment for toenail Onychomycosis (toenail fungus).

THE MEMBER'S RIGHT TO REQUEST AN EXCLUSION EXCEPTION

When a Prescription Drug Product is excluded from coverage, the Member or the Member's 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 the Member's ID card. UnitedHealthcare will notify the Member of UnitedHealthcare's determination within 72 hours.

Urgent Requests

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

External Review

If the Member are not satisfied with UnitedHealthcare's determination of the Member's exclusion exception request, the Member may be entitled to request an external review. The Member or the Member's 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 the Member's ID card. The *Independent Review Organization (IRO)* will notify the Member of UnitedHealthcare's determination within 72 hours.

Expedited External Review

If the Member is not satisfied with UnitedHealthcare's determination of the Member's exclusion exception request and it involves an urgent situation, the Member or the Member's representative may request an expedited external review by calling the toll-free number on the Member's ID card or by sending a written request to the address set

out in the determination letter. The *IRO* will notify the Member of UnitedHealthcare's determination within 24 hours.

Patient Protection and Affordable Care Act (PPACA) Preventive Care Medications Addendum

UnitedHealthcare Insurance Company of the River Valley

As described in this addendum, benefits for Preventive Care Medications described in the drug rider are modified as stated below.

Because this addendum is part of a legal document (the Group Health Contract), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* and in this addendum below.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of the River Valley . When we use the words "you" and "your," we are referring to people who are Subscribers, as that term is defined in the *Certificate.*

Benefits for Preventive Care Medications

Benefits under the drug rider include those for Preventive Care Medications as defined below. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Service* at the telephone number on your ID card.

Defined Terms

The following definition of Preventive Care Medications is added to the drug rider:

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Fill, Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any otherwise applicable Drug Copayment, Drug Coinsurance, Drug Deductible, Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Service* at the telephone number on your ID card.

Robert Broomfield, President

Addendum - Your Right to Request an Exclusion Exception

UnitedHealthcare Insurance Company of the River Valley

As described in this addendum, you have the right to request an exception for an excluded Prescription Drug Product as described below.

When a Prescription Drug Product is excluded from coverage, 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.

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 exclusion 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 exclusion 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 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.

Robert Broomfield, President

LANGUAGE ASSISTANCE SERVICES

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

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

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

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

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

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

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

注意事項：日本語**(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

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

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

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo 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 telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

NOTICE OF NON-DISCRIMINATION

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

[1] For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

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

Patient Protection and Affordable Care Act (PPACA)

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

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

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

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.
- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.
- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law.* This law amends *ERISA, the Public Health Service Act,* and the *Internal Revenue Code* and requires group health plans,

which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, in-Network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

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

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

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

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

Pre-Existing Conditions:

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

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for Policies that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Some Important Information about Appeal and External Review Rights under PPACA

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

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

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

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits.*

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (http://www.dol.gov.ebsa/healthreform/ - click link for Consumer Assistance Programs).

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998,* Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

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

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

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

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

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits 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 care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it

within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; 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 our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

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

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services,* if necessary, to make sure your privacy is protected.

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

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - 1. HIV/AIDS;
    - 2. Mental health;
    - 3. Genetic tests;
    - 4. Alcohol and drug abuse;
    - 5. Sexually transmitted diseases and reproductive health information; and
    - 6. Child or adult abuse or neglect, including sexual assault.

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

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communicati ons on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connextions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare

Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. Show the categories of health information that are subject to these more restrictive laws; and
2. Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, CT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA

Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NY, NM, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA).*

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration.*

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description.* The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA.*

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA,* there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor,* or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,* 200 Constitution Avenue, N.W., Washington,

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*