

**2015**  
**AGREEMENT**  
**UNITEDHEALTH CARE**  
**INSURANCE COMPANY**

**THIS AGREEMENT to purchase insurance policies** is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the “City”) and UnitedHealth Care Insurance Company, 185 Asylum Street, Hartford, CT 06103-0450 (the “**Insurance Company**”), jointly “the parties”.

The parties agree as follows:

**1. COORDINATION AND LIAISON:** The Insurance Company shall fully coordinate the purchase of agreed policies with the Executive Director of the Office of Human Resources or the Executive Director’s designee (“**Executive Director**”).

**a.** The Executive Director shall be authorized to sign the attached insurance policies listed in Exhibit A, hereto, and any other policy-related documents necessary for implementation or administration.

**2. SERVICES TO BE PERFORMED:**

**a.** As the Executive Director directs, the Insurance Company shall diligently work to sell to the City, the insurance policies listed in **Exhibit A**, to the City’s satisfaction.

**b.** The terms of this Agreement shall control if the terms of the attached Policies are in conflict..

**3. TERM:** This Agreement and the underlying insurance policies shall be effective January 1, 2015 (“Effective Date”), and will expire December 31, 2015 (the “Term”). The insurance policies listed in Exhibit A shall expire at the end of the Term.

**4. COMPENSATION AND PAYMENT:**

**a. Fee:** The City shall pay, and the Insurance Company shall accept as the sole compensation, the Maximum Contract Amount in monthly payments as required in the policies attached in Exhibit A, as full payment for the policies. Notwithstanding any other provision, if a policy is cancelled by the City prior to the end of the Term, the City shall be responsible to pay all pro rata amounts due through the end of the calendar month of termination.

b. **Reimbursable Expenses:** There are no reimbursable expenses allowed under this Agreement. Notwithstanding any term in the Policy to the contrary, the Insurance Company will not collect or attempt to collect any direct cost associated with the Policies purchased by the City. Further, the Insurance Company agrees not to adjust the Policy Premiums at any time prior to the termination of this Agreement”

c. **Maximum Contract Amount:**

(1) Notwithstanding any other provision of the Agreement, the City’s maximum payment obligation will not exceed **FIFTY-FOUR MILLION FOUR HUNDRED THIRTY THOUSAND ONE HUNDRED TWELVE AND 00/100 dollars (\$54,430,112.00)** (the “**Maximum Contract Amount**”) for the policies listed in Exhibit A. The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by Insurance Company beyond that specifically described in Exhibit A. Any services performed beyond those in Exhibit A are performed at Insurance Company’s risk and without authorization under this Agreement.

(2) The City’s payment obligation, whether direct or contingent, extends only to funds appropriated annually by the Denver City Council, paid into the Treasury of the City, and encumbered for the purpose of the Agreement. The City does not by this Agreement irrevocably pledge present cash reserves for payment or performance in future fiscal years. The Agreement does not and is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

5. **STATUS OF INSURANCE COMPANY:** The Insurance Company is an independent contractor. Neither the Insurance Company nor any of its employees are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code, or for any purpose whatsoever.

6. **TERMINATION:**

a. The City has the right to terminate this Agreement and any policy listed in Exhibit A, or all policies, with or without cause upon thirty (30) days prior written notice to the Insurance Company or under the terms of the policies as referenced in Exhibit A.

b. Upon termination the Insurance Company shall have no claim against the City by reason of, or arising out of, incidental or relating to termination, except for compensation due under a policy for the month of termination.

7. **EXAMINATION OF RECORDS:** Any authorized agent of the City, including the City Auditor or his or her representative, has the right to reasonable access and the right to examine any pertinent books, documents, papers and records of the Insurance Company, involving transactions related to the Agreement, during reasonable hours and until the latter of three (3) years after the final payment under the Agreement or expiration of the applicable statute of limitations. Nothing in this provision shall require the Insurance Company to make disclosures in violation of state or federal privacy laws.

8. **WHEN RIGHTS AND REMEDIES NOT WAIVED:** In no event will any payment or other action by the City constitute or be construed to be a waiver by the City of any breach of covenant or default that may then exist on the part of the Insurance Company. No payment, other action, or inaction by the City when any breach or default exists will impair or prejudice any right or remedy available to it with respect to any breach or default. No assent, expressed or implied, to any breach of any term of the Agreement constitutes a waiver of any other breach.

9. **INSURANCE:**

a. **General Conditions:** Insurance Company agrees to secure, at or before the time of execution of this Agreement, the following insurance covering all operations, goods or services provided pursuant to this Agreement. Insurance Company shall keep the required insurance coverage in force at all times during the term of the Agreement, or any extension thereof, during any warranty period, and for three (3) years after termination of the Agreement. The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado and rated by A.M. Best Company as "A-"VIII or better. Each policy shall contain a valid provision or endorsement requiring notification to the City in the event any of the above- described policies are canceled before the expiration date thereof. Such written notice shall be sent to the parties identified in the Notices section of this Agreement and shall reference the City contract number listed on the signature page of this Agreement. Said notice shall be sent thirty (30) days prior to such cancellation unless due to non- payment of premiums for which notice shall be sent ten (10) days prior. If such written notice is unavailable from the insurer, Insurance Company shall provide written notice of cancellation, non-renewal and any reduction in coverage to the parties identified in the Notices section within three (3) business days of

such notice by its insurer(s) and referencing the City's contract number. Insurance Company shall be responsible for the payment of any deductible or self-insured retention. The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Insurance Company. The Insurance Company shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

b. **Proof of Insurance:** Insurance Company may not commence services or work relating to the Agreement prior to placement of coverages required under this Agreement. Insurance Company certifies that the certificate of liability insurance, attached as **Exhibit B**, preferably an ACORD certificate, complies with all insurance requirements of this Agreement. The City requests that the City's contract number be referenced on the Certificate. The City's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Insurance Company's breach of this Agreement or of any of the City's rights or remedies under this Agreement.

c. **Waiver of Subrogation:** For all coverages, except the professional and technology E & O, Insurance Company's insurer shall waive subrogation rights against the City.

d. **Workers' Compensation/Employer's Liability Insurance:** Insurance Company shall maintain the coverage as required by statute for each work location and shall maintain Employer's Liability insurance with limits of \$100,000 per occurrence for each bodily injury claim, \$100,000 per occurrence for each bodily injury caused by disease claim, and \$500,000 aggregate for all bodily injuries caused by disease claims. Insurance Company expressly represents to the City, as a material representation upon which the City is relying in entering into this Agreement, that none of the Insurance Company's officers or employees who may be eligible under any statute or law to reject Workers' Compensation Insurance shall effect such rejection during any part of the term of this Agreement, and that any such rejections previously effected, have been revoked as of the date Insurance Company executes this

Agree  
ment.

- e. **Commercial General Liability:** Insurance Company shall maintain a

Commercial General Liability insurance policy with limits of \$1,000,000 for each occurrence,

\$1,000,000 for each personal and advertising injury claim, \$2,000,000 products and completed operations aggregate, and \$2,000,000 policy aggregate.

f. **Business Automobile Liability:** Insurance Company shall maintain Business Automobile Liability with limits of \$1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this Agreement.

g. **Professional Liability (Errors & Omissions):** Insurance Company shall maintain limits of \$1,000,000 per claim and \$1,000,000 policy aggregate limit.

h. **Cyber Liability:** Contractor shall maintain Cyber Liability coverage with limits of \$1,000,000 per occurrence and \$1,000,000 policy aggregate covering third party claims involving privacy violations, information theft, and intentional and/or unintentional release of private information.

#### 10. **DEFENSE AND INDEMNIFICATION**

a. To the fullest extent permitted by law, Insurance Company hereby agrees to defend, indemnify, reimburse and hold harmless City, its appointed and elected officials, agents and employees for, from and against all liabilities, claims, judgments, suits or demands for damages to persons or property arising out of, resulting from, or related to the work performed under this Agreement that are due to the negligence or fault of Insurance Company or Insurance Company's agents, representatives, subcontractors, or suppliers ("**Claims**"). This indemnity shall be interpreted in the broadest possible manner consistent with the applicable law to indemnify the City.

b. Insurance Company's duty to defend and indemnify City shall arise at the time written notice of the Claim is first provided to City regardless of whether suit has been filed and even if Insurance Company is not named as a Defendant.

c. Insurance Company will defend any and all Claims which may be

brought or threatened against City and will pay on behalf of City any expenses incurred by reason of such Claims including, but not limited to, court costs and attorney fees incurred in defending and investigating such Claims or seeking to enforce this indemnity obligation. Such payments on behalf of City shall be in addition to any other legal remedies available to City and shall not be considered City's exclusive remedy.

d. Insurance coverage requirements specified in this Agreement shall in no way lessen or limit the liability of the Insurance Company under the terms of this indemnification obligation. Insurance Company shall obtain, at its own expense, any additional insurance that it deems necessary for the City's protection.

e. This defense and indemnification obligation shall survive the expiration or termination of this Agreement.

11. **TAXES, CHARGES AND PENALTIES:** The City is not liable for the payment of taxes, late charges or penalties of any nature, except for any additional amounts that the City may be required to pay under the City's prompt payment ordinance D.R.M.C. § 20-107, *et seq.* The Insurance Company shall promptly pay when due, all taxes, bills, debts and obligations it incurs performing the services under the Agreement and shall not allow any lien, mortgage, judgment or execution to be filed against City property.

12. **ASSIGNMENT; SUBCONTRACTING:** Except as provided in this provision, the Insurance Company shall not voluntarily or involuntarily assign any of its rights or obligations, or subcontract performance obligations, under this Agreement without obtaining the Executive Director's prior written consent. That consent will not be unreasonably withheld. Nevertheless, Insurance Company can assign this Agreement, including its rights and obligations to Insurance Company's affiliates, to an entity controlling, controlled by, or under common control with Insurance Company, or a purchase of all or substantially all of Insurance Company's assets, subject to notice to the City of the assignments. Any assignment or subcontracting without such consent will be ineffective and void, and will be cause for termination of this Agreement by the City. The Executive Director has sole and absolute discretion whether to consent to any assignment or subcontracting, or to terminate the Agreement because of unauthorized assignment or subcontracting. In the event of any subcontracting or unauthorized

assignment: (i) the Insurance Company shall remain responsible to the City; and (ii) no contractual relationship shall be created between the City and any sub- Insurance Company, subcontractor or assign.

**13. INUREMENT:** The rights and obligations of the parties to the Agreement inure to the benefit of and shall be binding upon the parties and their respective successors and assigns, provided assignments are consented to in accordance with the terms of the Agreement.

**14. NO THIRD PARTY BENEFICIARY:** Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the City or the Insurance Company receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

**15. GRANT OF LIMITED LICENSE TO USE LOGO**

**a.** City hereby grants to Insurance Company, subject to the terms and conditions set forth herein, a non-exclusive, nontransferable limited license, to use the “Denver D” logo (“**Denver Logo**”) during the Term of this Agreement.

**b.** Insurance Company shall fully coordinate all logo use under this Agreement with the Denver Marketing Office ((720) 913-1633, [denvermarketing@denvergov.org](mailto:denvermarketing@denvergov.org)), or otherwise as directed by the City.

**c.** The use of the Denver Logo is limited to display on the website to be created by Insurance Company pursuant to this Agreement and for the purpose of identification only. Insurance Company shall display the Denver Logo in a read-only format and shall not be used or displayed on the website in any format from which it can be downloaded, copied or reproduced in any manner.

**d.** The license granted by the City is non-transferable and non-assignable to anyone other than those acting under the supervision and authority of Insurance Company.

**e.** Insurance Company shall be solely responsible for the entire cost and expense of Consultant’s Use of the Denver Logo.

**f.** The Denver Logo may not be used as a feature or design element of any other logo or graphic.

**g.** Insurance Company shall use the Denver Logo in accordance with any and all logo usage guidelines in effect from time-to-time as provided by the City. Consultant shall use only accurate reproductions of the Denver Logo. The size, proportions, colors, elements, and other distinctive characteristics of the Denver Logo shall not be altered in any manner except as may be permitted herein or as permitted in writing by the City.

**h.** Insurance Company may use the colors set forth in the “Denver Logo Colors” document, (attached hereto as “**Exhibit C**”) or it may use black or shades of gray.

**i.** Insurance Company shall affix a trademark (“™”) or registration (“®”) indication next to the Denver Logo as directed by the Denver Marketing Office.

**j.** Insurance Company shall immediately cease all use of the Denver Logo upon expiration of the Term of this Agreement, as may have been extended from time to time by the parties, in a formal written extension of this agreement.

**16. NO AUTHORITY TO BIND CITY TO CONTRACTS:** The Insurance Company lacks any authority to bind the City on any contractual matters. Final approval of all contractual matters that purport to obligate the City must be executed by the City in accordance with the City’s Charter and the Denver Revised Municipal Code.

**17. SEVERABILITY:** Except for the provisions of the Agreement requiring appropriation of funds and limiting the total amount payable by the City, if a court of competent jurisdiction finds any provision of the Agreement or any portion of it to be invalid, illegal, or unenforceable, the validity of the remaining portions or provisions will not be affected, if the intent of the parties can be fulfilled.

**18. CONFLICT OF INTEREST:**

**a.** No employee of the City shall have any personal or beneficial interest in the services or property described in the Agreement. The Insurance Company shall not hire, or contract for services with, any employee or officer of the City that would be in violation of the City’s Code of Ethics, D.R.M.C. §2-51, et seq. or the Charter §§ 1.2.8, 1.2.9, and 1.2.12.

**b.** The Insurance Company shall not engage in any transaction, activity or conduct that would result in a conflict of interest under the Agreement. The Insurance Company represents that it has disclosed any and all current or potential conflicts of interest.



A conflict of interest shall include transactions, activities or conduct that would affect the judgment, actions or work of the Insurance Company by placing the Insurance Company's own interests, or the interests of any party with whom the Insurance Company has a contractual arrangement, in conflict with those of the City. The City, in its sole discretion, will determine the existence of a conflict of interest and may terminate the Agreement if it determines a conflict exists, after it has given the Insurance Company written notice describing the conflict.

**19. NOTICES:** Policy restrictions notwithstanding, all notices required by the terms of the Agreement must be hand delivered, sent by overnight courier service, mailed by certified mail, return receipt requested, or mailed via United States mail, postage prepaid, if to Insurance Company at the address first above written, and if to the City at:

Executive Director  
Office Human Resources  
201 West Colfax Avenue, Dept. 412  
Denver, Colorado 80202

With a copy of any such notice to:

Denver City Attorney's Office  
1437 Bannock St., Room 353  
Denver, Colorado 80202

Notices hand delivered or sent by overnight courier are effective upon delivery. Notices sent by certified mail are effective upon receipt. Notices sent by mail are effective upon deposit with the U.S. Postal Service. The parties may designate substitute addresses where or persons to whom notices are to be mailed or delivered. However, these substitutions will not become effective until actual receipt of written notification.

**20. NO EMPLOYMENT OF ILLEGAL ALIENS TO PERFORM WORK UNDER THE AGREEMENT:**

**a.** This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, and any amendments (the "Certification Ordinance").

**b.** The Insurance Company certifies that:

- (1) At the time of its execution of this Agreement, it does not knowingly employ or contract with an illegal alien who will perform work under this Agreement.
- (2) It will participate in the E-Verify Program, as defined in § 8-

17.5-

101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired

for employment to perform work under this Agreement.

**c.** The Insurance Company also agrees and represents that:

**(1)** It shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

**(2)** It shall not enter into a contract with a subconsultant or subcontractor that fails to certify to the Insurance Company that it shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

**(3)** It has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement, through participation in either the E-Verify Program.

**(4)** It is prohibited from using either the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligations under the Agreement, and it is required to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights.

**(5)** If it obtains actual knowledge that a subconsultant or subcontractor performing work under the Agreement knowingly employs or contracts with an illegal alien, it will notify such subconsultant or subcontractor and the City within three (3) days. The Insurance Company shall also terminate such subconsultant or subcontractor if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with the illegal alien, unless during such three-day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with an illegal alien.

**(6)** It will comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-

17.5-102(5), C.R.S., or the City Auditor, under authority of D.R.M.C. 20-90.3.

**d.** The Insurance Company is liable for any violations as provided in the Certification Ordinance. If Insurance Company violates any provision of this section or the Certification Ordinance, the City may terminate this Agreement for a breach of the Agreement. If the Agreement is so terminated, the Insurance Company shall be liable for

actual and consequential damages to the City. Any such termination of a contract due to a violation of this section or the Certification Ordinance may also, at the discretion of the City, constitute grounds for disqualifying Insurance Company from submitting bids or proposals for future contracts with the City.

**21. DISPUTES:** The Parties agree that Section 6.2 of the Policy entitled “Dispute Resolution” shall not be binding on the City. In the event of dispute, the complaining party will notify the other party in writing. The Parties will both make efforts to resolve the complaint. If the complaint is not resolved within 30 days of the notice of complaint, the complaining party is free to begin litigation of the issue in any appropriate venue.

**22. GOVERNING LAW; VENUE:** The Agreement will be construed and enforced in accordance with applicable federal law, the laws of the State of Colorado, and the applicable Charter, Revised Municipal Code, ordinances, regulations and Executive Orders of the City and County of Denver, which are expressly incorporated into the Agreement. Unless otherwise specified, any reference to statutes, laws, regulations, charter or code provisions, ordinances, executive orders, or related memoranda, includes amendments or supplements to same. Venue for any legal action relating to the Agreement will be in the District Court of the State of Colorado, Second Judicial District (Denver District Court).

**23. NO DISCRIMINATION IN EMPLOYMENT:** In connection with the performance of work under the Agreement, the Insurance Company may not refuse to hire, discharge, promote or demote, or discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, gender variance, marital status, or physical or mental disability. The Insurance Company shall insert similar foregoing provision in all subcontracts.

**24. COMPLIANCE WITH ALL LAWS:** Insurance Company shall perform or cause to be performed all services, both in this Agreement and pursuant to any insurance policies referenced in Exhibit A, in full compliance with all applicable laws, rules, regulations and codes of the United States, the State of Colorado; and with the applicable Charter, ordinances, rules, regulations and Executive Orders of the City and County of Denver.

25. **LEGAL AUTHORITY:** Insurance Company represents and warrants that it possesses the legal authority, pursuant to any proper, appropriate and official motion, resolution or action passed or taken, to enter into the Agreement. Each person signing and executing the Agreement on behalf of Insurance Company represents and warrants that he has been fully authorized by Insurance Company to execute the Agreement on behalf of Insurance Company and to validly and legally bind Insurance Company to all the terms, performances and provisions of the Agreement. The City shall have the right, in its sole discretion, to either temporarily suspend or permanently terminate the Agreement if there is a dispute as to the legal authority of either Insurance Company or the person signing the Agreement to enter into the Agreement.

26. **NO CONSTRUCTION AGAINST DRAFTING PARTY:** The parties and their respective counsel have had the opportunity to review the Agreement, and the Agreement will not be construed against any party merely because any provisions of the Agreement were prepared by a particular party.

27. **ORDER OF PRECEDENCE:** In the event of any conflicts between the language of the Agreement and the exhibits, the language of the Agreement controls, unless such language of the Agreement is severed because it was held to be invalid, illegal, or unenforceable in any respect.

28. **SURVIVAL OF CERTAIN PROVISIONS:** The terms of the Agreement and any exhibits and attachments that by reasonable implication contemplate continued performance, rights, or compliance beyond expiration or termination of the Agreement survive the Agreement and will continue to be enforceable. Without limiting the generality of this provision, the Insurance Company's obligations to provide insurance and to indemnify the City will survive for a period equal to any and all relevant statutes of limitation, plus the time necessary to fully resolve any claims, matters, or actions begun within that period.

29. **ADVERTISING AND PUBLIC DISCLOSURE:** The Insurance Company shall not include any reference to the Agreement or to services performed pursuant to the Agreement in any of the Insurance Company's advertising or public relations materials without first obtaining the written approval of the Executive Director. Any oral presentation or written materials related to services performed under the Agreement will be limited to services that have been accepted by the City. The Insurance Company shall

notify the Executive Director in advance of the date and time of any presentation. Nothing in this provision precludes the transmittal of any information to City officials

**30. CONFIDENTIAL INFORMATION:**

a. **City Information:** Insurance Company acknowledges and accepts that, in performance of all work under the terms of this Agreement, Insurance Company may have access to Proprietary Data or confidential information that may be owned or controlled by the City, and that the disclosure of such Proprietary Data or information may be damaging to the City or third parties. Insurance Company agrees that all Proprietary Data, confidential information or any other data or information provided or otherwise disclosed by the City to Insurance Company shall be held in confidence and used only in the performance of its obligations under this Agreement. Insurance Company shall exercise the same standard of care to protect such Proprietary Data and information as a reasonably prudent Insurance Company would to protect its own proprietary or confidential data. "Proprietary Data" shall mean any materials or information which may be designated or marked "Proprietary" or "Confidential", or which would not be documents subject to disclosure pursuant to the Colorado Open Records Act or City ordinance, and provided or made available to Insurance Company by the City. Such Proprietary Data may be in hardcopy, printed, digital or electronic format.

**31. CITY EXECUTION OF AGREEMENT:** The Agreement will not be effective or binding on the City until it has been fully executed by all required signatories of the City and County of Denver, and if required by Charter, approved by the City Council.

**32. AGREEMENT AS COMPLETE INTEGRATION-AMENDMENTS:** The Agreement is the complete integration of all understandings between the parties as to the subject matter of the Agreement. No prior, contemporaneous or subsequent addition, deletion, or other modification has any force or effect, unless embodied in the Agreement in writing. No oral representation by any officer or employee of the City at variance with the terms of the Agreement or any written amendment to the Agreement will have any force or effect or bind the City.

**33. USE, POSSESSION OR SALE OF ALCOHOL OR DRUGS:** Insurance Company shall cooperate and comply with the provisions of Executive Order 94 and its Attachment A concerning the use, possession or sale of alcohol or drugs.

**34. ELECTRONIC SIGNATURES AND ELECTRONIC RECORDS:**

Insurance Company consents to the use of electronic signatures by the City. The Agreement, and any other documents requiring a signature under the Agreement, may be signed electronically by the City in the manner specified by the City. The Parties agree not to deny the legal effect or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The Parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

**[THIS SPACE INTENTIONALLY LEFT BLANK]**

**Contract Control Number:**

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of

SEAL

**CITY AND COUNTY OF DENVER**

ATTEST:

By \_\_\_\_\_

\_\_\_\_\_

APPROVED AS TO FORM:

REGISTERED AND COUNTERSIGNED:

By \_\_\_\_\_

By \_\_\_\_\_

By \_\_\_\_\_



**Contract Control Number:** CSAHR-201521976-00

**Contractor Name:** United Healthcare

By: Elizabeth Soberg Prokocki

Name: Elizabeth Soberg Prokocki  
(please print)

Title: President & CEO, UHC, Desert Mountain States  
(please print)

**ATTEST: [if required]**

By: \_\_\_\_\_

Name: \_\_\_\_\_  
(please print)

Title: \_\_\_\_\_  
(please print)





**EXHIBIT A  
INSURANCE POLICIES**

**UnitedHealth Care Company  
GROUP POLICY**

# **UnitedHealthcare Insurance Company**

## **Group Policy**

**For**

**City and County of Denver**

**Enrolling Group Number: 717340**

**Policy Effective Date: January 1, 2015**

# **UnitedHealthcare Insurance Company**

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

# Group Policy

## UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

## Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

**Coverage Classification** - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

**Material Misrepresentation** - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

## Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

## Article 3: Premium Rates and Policy Charge

### 3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation relating to health status that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

### 3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

### 3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 60 days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber or any Dependent of the Subscriber has received Benefits.

The Enrolling Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

Subject to the terms specified in item 5 of Exhibit 1, the Enrolling Group is liable for payment of the Premium charged for each Covered Person through the date the Enrolling Group notifies us in writing that the Covered Person is no longer eligible for coverage under this Policy.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, or any change in law or regulation that significantly affects our cost of operation, those charges will result in an increase in Premium in an amount we determine in accordance with item 4 of Exhibit 1. Charges to recoup assessments paid for CoverColorado will be billed at any time at our discretion, after the assessments have been paid.

### **3.4 Payment of the Policy Charge**

The Policy Charge is payable to us in advance by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

### **3.5 Grace Period**

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

## **Article 4: Eligibility and Enrollment**

### **4.1 Eligibility Conditions or Rules**

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

## **4.2 Initial Enrollment Period**

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

## **4.3 Open Enrollment Period**

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

## **4.4 Effective Date of Coverage**

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

# **Article 5: Policy Termination**

## **5.1 Conditions for Termination of the Entire Policy**

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

- A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.
- B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated or the date of notification if later.
- C. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation and contribution rules as shown in Exhibit 1.
- D. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:
  - The effective date of this Policy.
  - The date of the act, practice or omission, if later.
- E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.
- F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

## **5.2 Payment and Reimbursement Upon Termination**

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including:

- A pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.
- A full or pro rata Policy Charge, whichever is applicable, for any period this Policy was in force prior to the termination date requested by the Enrolling Group or the date of notification of requested termination, or later.

## **Article 6: General Provisions**

### **6.1 Entire Policy**

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

### **6.2 Dispute Resolution**

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

Arbitration will take place in Hartford County, Connecticut.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by controlling law.

### **6.3 Time Limit on Certain Defenses**

No statement made by the Enrolling Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

### **6.4 Amendments and Alterations**

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Other than changes to Exhibit 2 stated in a Notice of Change to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

### **6.5 Relationship between Parties**

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.



The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

## **6.6 Records**

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

## **6.7 Administrative Services**

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

## **6.8 Examination of Covered Persons**

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

## **6.9 Clerical Error**

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive

coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

### **6.10 Workers' Compensation Not Affected**

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

### **6.11 Conformity with Law**

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

### **6.12 Notice**

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

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

### **6.13 Continuation Coverage**

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends of the Certificate of Coverage*.

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

### **6.14 Certification of Coverage Forms**

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

### **6.15 Subscriber's Individual Certificate**

We will issue *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage and Schedule(s) of Benefits* online at [www.myuhc.com](http://www.myuhc.com).

## **6.16 System Access**

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

### **System Access**

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

### **Security Procedures**

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

### **System Access Termination**

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

# Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and City and County of Denver, the Enrolling Group.
2. **Effective Date of this Policy.** The effective date of this Policy is 12:01 a.m. on January 1, 2015 in the time zone of the Enrolling Group's location.
3. **Place of Issuance.** We are delivering this Policy in the State of Colorado. The laws of the State of Colorado are the laws that govern this Policy.
4. **Premiums.** We reserve the right to change the *Schedule of Premium Rates* specified in each Exhibit 2, after a 45-day prior written notice at any time. We also reserve the right to change the *Schedule of Premium Rates* at any time, retroactive to the effective date, if a Material Misrepresentation relating to health status has resulted in a lower schedule of rates.
5. **Computation of Policy Charge.** A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.
6. **Payment of the Policy Charge.** The Policy Charge is payable to us in advance by the Enrolling Group on a monthly basis.
7. **Minimum Participation Requirement.** The minimum participation requirement for the Enrolling Group is 50% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.
8. **Minimum Contribution Requirement.** The Enrolling Group must maintain a minimum contribution requirement of 95% of the Premium for each Eligible Person.
9. **Notice.** Any notice sent to us under this Policy must be addressed to:  
  
UnitedHealthcare Insurance Company  
  
185 Asylum Street  
  
Hartford, Connecticut 06103-0450  
  
  
Any notice sent to the Enrolling Group under this Policy must be addressed to:  
  
City and County of Denver  
  
201 W. Colfax Dept. 412  
  
Denver, Colorado 80202
10. 717340: Enrolling Group Number

# Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

All Police Officers enrolled in United Healthcare Navigate Plan VX7.

2. **Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows:

None

B. Other:

Part-Time Employees and Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period.** An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

<b>Coverage Classification</b>	<b>Monthly Premium</b>
Employee Only	\$477.42
Employee plus Spouse	\$1,050.34
Employee plus Child(ren)	\$954.86
Employee plus Family	\$1,527.74

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

## Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

All Non-Police Employees enrolled in United Healthcare Navigate Plan VX7.

2. **Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows:

None

B. Other:

Part-Time Employees and Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period.** An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

<b>Coverage Classification</b>	<b>Monthly Premium</b>
Employee Only	\$638.27
Employee plus Spouse	\$1,404.21
Employee plus Child(ren)	\$1,276.58
Employee plus Family	\$2,042.82

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

## Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

All Police Officers enrolled in United Healthcare Choice Plan VXP.

2. **Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows:

None

B. Other:

Part-Time Employees and Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period.** An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

<b>Coverage Classification</b>	<b>Monthly Premium</b>
Employee Only	\$656.06
Employee plus Spouse	\$1,443.36
Employee plus Child(ren)	\$1,312.15
Employee plus Family	\$2,099.39

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

## Exhibit 2 Class 4

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

All Non-Police Employees enrolled in United Healthcare Choice Plan VXP.

2. **Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows:

None

B. Other:

Part-Time Employees and Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period.** An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2015.

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2015 is shown below:

<b>Coverage Classification</b>	<b>Monthly Premium</b>
Employee Only	\$877.44
Employee plus Spouse	\$1,930.39
Employee plus Child(ren)	\$1,754.93
Employee plus Family	\$2,808.31

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.



## Exhibit 3

### Wellness Program Stipend

Enrolling Group is eligible for a wellness stipend up to \$25,000 during the contract year for the purpose of establishing, implementing and maintaining a wellness program that increases awareness of health risks and supports behavior change.

Enrolling Group will collaborate with our representatives to define and plan wellness services and program strategies:

- Awareness and Education activities may include, but are not limited to biometric screenings and health kiosks.
- Behavioral Change activities may include, but are not limited to health and wellness educational programs such as smoking cessation and Weight Watchers.
- Environmental Change activities may include but are not limited to activities such as onsite exercise classes and/or equipment.
- Incentives which encourage or reward participation in wellness programs.

Enrolling Group will maintain and provide documentation to us of program costs and related expenditures.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Summary of Benefits and Coverage Policy Amendment

## UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to address requirements for delivery of the *Summary of Benefits and Coverage (SBC)* as required under the *Affordable Care Act* and associated regulations (*ACA*).

The following provision is added to the Policy under *Article 6: General Provisions*:

### Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage ("SBC")*, as required by the *Affordable Care Act* and associated regulations ("*ACA*"), to the Enrolling Group for each benefit plan purchased by the Enrolling Group. The Enrolling Group shall be responsible for delivering the *SBC* to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the *ACA*, unless we notify the Enrolling Group that we will deliver the *SBC* to Covered Persons and other persons eligible for coverage.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Summary of the Life and Health Insurance Protection Association Act and Notice Concerning Coverage Limitations and Exclusions

## Introduction

Residents of Colorado who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Life and Health Insurance Protection Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

## Important Disclaimer

**The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection Association in selecting an insurance company or in selecting an insurance policy.**

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.**

**Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.**

## Summary

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

## Coverage

Generally, individuals will be protected by the Life and Health Protection Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

This Information is Provided By:

**Life and Health Insurance Protection Association**

P. O. Box 36009

Denver, Colorado 80236

(303) 292-5022

**Colorado Division of Insurance**

1560 Broadway, Suite 850

Denver, Colorado 80202

(303) 894-7499

## **Exclusions From Coverage**

Persons holding such policies are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991 and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;

- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

## **Limits on Amount of Coverage**

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- \$300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - \$100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values; \$300,000 for disability insurance or \$500,000 for basic hospital, medical and surgical, or major medical insurance;
- \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- with respect to each payee of a structured settlement annuity, \$250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values; or
- \$300,000 for long term care benefits.

The Association shall not be liable to expend more than \$300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the Association shall not exceed \$500,000 with respect to any one individual.

**EXHIBIT A-1  
INSURANCE POLICIES**

**UnitedHealth Care Company  
NAVIGATE POLICY**

**UnitedHealthcare Navigate**  
**UnitedHealthcare Insurance Company**

**Certificate of Coverage**

**For**

**the Plan VX7**

**of**

**City and County of Denver**

**Enrolling Group Number: 717340**

**Effective Date: January 1, 2015**

**Offered and Underwritten by**

**UnitedHealthcare Insurance Company**

# **UnitedHealthcare Insurance Company**

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000



# Table of Contents

<b>Schedule of Benefits .....</b>	<b>1</b>
Selecting a Primary Physician .....	1
Accessing Benefits .....	1
Prior Authorization .....	2
Covered Health Services which Require Prior Authorization .....	2
Care Management.....	3
Special Note Regarding Medicare.....	3
Benefits.....	3
Additional Benefits Required By Colorado Law.....	15
Eligible Expenses .....	17
Provider Network .....	18
Designated Facilities and Other Providers .....	18
Health Services from Non-Network Providers.....	19
<b>Certificate of Coverage.....</b>	<b>1</b>
Certificate of Coverage is Part of Policy.....	1
Changes to the Document.....	1
Other Information You Should Have .....	1
<b>Introduction to Your Certificate .....</b>	<b>3</b>
How to Use this Document.....	3
Information about Defined Terms .....	3
Don't Hesitate to Contact Us .....	3
Access Plan.....	3
<b>Your Responsibilities .....</b>	<b>4</b>
Be Enrolled and Pay Required Contributions.....	4
Be Aware this Benefit Plan Does Not Pay for All Health Services .....	4
Decide What Services You Should Receive .....	4
Choose Your Physician .....	4
Obtain Prior Authorization .....	4
Pay Your Share .....	4
Pay the Cost of Excluded Services .....	5
Show Your ID Card.....	5
File Claims with Complete and Accurate Information .....	5
Use Your Prior Health Care Coverage .....	5
<b>Our Responsibilities.....</b>	<b>6</b>
Determine Benefits .....	6
Pay for Our Portion of the Cost of Covered Health Services .....	6
Pay Network Providers .....	6
Pay for Covered Health Services Provided by Non-Network Providers.....	6
Review and Determine Benefits in Accordance with our Reimbursement Policies .....	6
Offer Health Education Services to You.....	7
<b>Certificate of Coverage Table of Contents.....</b>	<b>8</b>
<b>Section 1: Covered Health Services .....</b>	<b>9</b>
Benefits for Covered Health Services .....	9
1. Ambulance Services.....	9
2. Congenital Heart Disease Surgeries .....	10
3. Dental Services - Accident Only .....	10
4. Diabetes Services.....	10
5. Durable Medical Equipment .....	11
6. Emergency Health Services - Outpatient .....	12
7. Hearing Aids for Adults.....	12

8. Hearing Aids for Minor Children .....	12
9. Home Health Care .....	13
10. Hospice Care .....	14
11. Hospital - Inpatient Stay .....	15
12. Lab, X-Ray and Diagnostics - Outpatient .....	15
13. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient .....	15
14. Mental Health Services.....	16
15. Neurobiological Disorders - Autism Spectrum Disorder Services .....	16
16. Ostomy Supplies .....	17
17. Pharmaceutical Products - Outpatient.....	18
18. Physician Fees for Surgical and Medical Services .....	18
19. Physician's Office Services - Sickness and Injury .....	18
20. Pregnancy - Maternity Services .....	18
21. Preventive Care Services .....	19
Additional preventive care services:.....	20
22. Prosthetic Devices .....	20
23. Reconstructive Procedures .....	21
24. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.....	21
25. Scopic Procedures - Outpatient Diagnostic and Therapeutic .....	22
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services .....	22
27. Substance Use Disorder Services.....	23
28. Surgery - Outpatient .....	24
29. Therapeutic Treatments - Outpatient .....	24
30. Transplantation Services .....	25
31. Urgent Care Center Services .....	25
32. Vision Examinations .....	25
Additional Benefits Required By Colorado Law.....	25
33. Autism Spectrum Disorders.....	25
34. Cleft Lip and Cleft Palate Treatment .....	26
35. Clinical Trials and Studies .....	26
36. Colorectal Cancer Screening .....	27
37. Hospitalization and General Anesthesia for Dental Procedures for Children .....	28
38. Phenylketonuria (PKU) Testing and Treatment .....	28
39. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities) .....	29
40. Telemedicine Services .....	29
<b>Section 2: Exclusions and Limitations.....</b>	<b>30</b>
How We Use Headings in this Section.....	30
We do not Pay Benefits for Exclusions .....	30
Benefit Limitations .....	30
A. Alternative Treatments .....	30
B. Dental.....	30
C. Devices, Appliances and Prosthetics.....	31
D. Drugs.....	32
E. Experimental or Investigational or Unproven Services .....	32
F. Foot Care .....	33
G. Medical Supplies.....	33
H. Mental Health.....	33
I. Neurobiological Disorders - Autism Spectrum Disorders .....	34
J. Nutrition.....	35
K. Personal Care, Comfort or Convenience .....	35
L. Physical Appearance.....	36
M. Procedures and Treatments .....	37
N. Providers .....	38
O. Reproduction .....	38

P. Services Provided under another Plan .....	38
Q. Substance Use Disorders .....	39
R. Transplants .....	39
S. Travel .....	39
T. Types of Care .....	40
U. Vision and Hearing .....	40
V. All Other Exclusions .....	40
<b>Section 3: When Coverage Begins .....</b>	<b>43</b>
How to Enroll .....	43
If You Are Hospitalized When Your Coverage Begins .....	43
Who is Eligible for Coverage .....	43
Eligible Person .....	43
Dependent .....	43
When to Enroll and When Coverage Begins .....	43
Initial Enrollment Period .....	44
Open Enrollment Period .....	44
Dependent Child Special Open Enrollment Period .....	44
New Eligible Persons .....	44
Adding New Dependents .....	44
Special Enrollment Period .....	45
<b>Section 4: When Coverage Ends .....</b>	<b>47</b>
General Information about When Coverage Ends .....	47
Events Ending Your Coverage .....	47
Other Events Ending Your Coverage .....	48
Coverage for a Disabled Dependent Child .....	48
Extended Coverage If You Are Hospitalized .....	48
Continuation of Coverage and Conversion .....	48
Qualifying Events for Continuation Coverage under State Law .....	49
Notification Requirements and Election Period for Continuation Coverage under State Law .....	49
Terminating Events for Continuation Coverage under State Law .....	50
Conversion .....	50
<b>Section 5: How to File a Claim .....</b>	<b>51</b>
If You Receive Covered Health Services from a Network Provider .....	51
If You Receive Covered Health Services from a Non-Network Provider .....	51
Required Information .....	51
Payment of Benefits .....	51
<b>Section 6: Questions, Complaints and Appeals .....</b>	<b>53</b>
What to Do if You Have a Question .....	53
What to Do if You Have a Complaint .....	53
How to Appeal a Claim Decision .....	53
Post-service Claims .....	53
Pre-service Requests for Benefits .....	53
How to Request an Appeal .....	53
Appeal Process .....	54
Appeals Determinations .....	54
Pre-service Requests for Benefits and Post-service Claim Appeals .....	54
Urgent Appeals that Require Immediate Action .....	54
Independent External Review Program .....	55
<b>Section 7: Coordination of Benefits .....</b>	<b>56</b>
Benefits When You Have Coverage under More than One Plan .....	56
When Coordination of Benefits Applies .....	56
Definitions .....	56
Order of Benefit Determination Rules .....	57
Effect on the Benefits of This Plan .....	59

Right to Receive and Release Needed Information .....	60
Payments Made.....	60
Right of Recovery .....	60
When Medicare is Secondary.....	60
<b>Section 8: General Legal Provisions .....</b>	<b>61</b>
Your Relationship with Us .....	61
Our Relationship with Providers and Enrolling Groups .....	61
Your Relationship with Providers and Enrolling Groups .....	62
Notice.....	62
Notice of Continuation .....	62
Notice of Conversion .....	62
Statements by Enrolling Group or Subscriber .....	63
Incentives to Providers .....	63
Incentives to You .....	63
Rebates and Other Payments .....	63
Interpretation of Benefits .....	63
Administrative Services .....	64
Amendments to the Policy.....	64
Information and Records .....	64
Examination of Covered Persons .....	65
Workers' Compensation not Affected.....	65
Subrogation and Reimbursement.....	65
Refund of Overpayments.....	67
Limitation of Action .....	67
Entire Policy.....	67
<b>Section 9: Defined Terms.....</b>	<b>68</b>

## **Amendments, Riders and Notices (As Applicable)**

### **Standard Section Names**

**Home Health Care and Hospice Care Amendment**

**Domestic Partner Amendment**

**Health Resources and Services Administration (HRSA) Amendment**

**Questions, Complaints and Appeals Amendment**

**Clinical Trials, Civil Unions and Patient Protection and Affordable Care Act (PPACA) Related 2014 Provisions Amendment**

**Outpatient Prescription Drug Rider**

**Routine Vision Examination Rider**

**Important Notices under the Patient Protection and Affordable Care Act (PPACA)**

**Changes in Federal Law that Impact Benefits**

**Women's Health and Cancer Rights Act of 1998**

**Statement of Rights under the Newborns' and Mothers' Health Protection Act**

**Claims and Appeal Notice**

**Health Plan Notices of Privacy Practices**

**Financial Information Privacy Notice  
Health Plan Notice of Privacy Practices: Federal and State  
Amendments**

# UnitedHealthcare Navigate

## UnitedHealthcare Insurance Company

### Schedule of Benefits

#### Selecting a Primary Physician

You must select a Primary Physician in order to obtain Benefits. A Primary Physician will be able to coordinate all Covered Health Services and make referrals for services from Network Physicians. If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Physician for that child. If you do not select a Primary Physician, one will be assigned to you.

You may select any Network Primary Physician who is accepting new patients. You may designate a pediatrician as the Primary Physician for an Enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Primary Physician and may seek care directly from any Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife. For eye care, you do not need a referral from a Primary Physician and may seek care directly from any Network optometrist or ophthalmologist.

You can obtain a list of Network Primary Physicians and/or Network obstetricians, gynecologists, advanced practice nurse who is a certified nurse midwife, optometrist or ophthalmologist by going to [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

You may change your Primary Physician by contacting *Customer Care* at the telephone number shown on your ID card. Changes are permitted once per month. Changes submitted on or before the 15th of the month will be effective on the first day of the following month. Changes submitted on or after the 16th of the month will be effective on the first day of the second following month.

#### Accessing Benefits

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

**Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Covered Health Services received at an Urgent Care Center outside your geographic area and Emergency Health Services.

Covered Health Services must be provided by or referred by your Primary Physician. If care from another Network Physician is needed, your Primary Physician will provide you with a referral. The referral must be received before the services are rendered. If you see a Network Physician without a referral from your Primary Physician, Benefits will not be paid. You do not need a referral to see an obstetrician/gynecologist, advanced practice nurse who is a certified nurse midwife, optometrist or ophthalmologist or to receive services through the Mental Health/Substance Use Disorder Designee.

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

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

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

## **Prior Authorization**

We recommend that you notify us before you receive certain Covered Health Services. Your Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which we recommend that you notify us to ensure that Benefits are available. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

**Please note that prior authorization is required even if you have a referral from your Primary Physician to seek care from another Network Physician.**

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

**To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

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

## **Covered Health Services which Require Prior Authorization**

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

- Ambulance - non-emergent air and ground.
- Autism Spectrum Disorders.
- Cleft Lip and Cleft Palate Treatment.
- Clinical Trials and Studies.
- Congenital heart disease surgery.
- Hospitalization and General Anesthesia for Dental Procedures for Children.
- Phenylketonuria (PKU) Testing and Treatment.
- Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities).
- Transplants.

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

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

## Care Management

When we are notified as recommended, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

## Special Note Regarding Medicare

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

## Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Mammography benefits are provided on a calendar year basis.

Payment Term And Description	Amounts
<b>Annual Deductible</b>	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Annual Deductible does not include any applicable Per</p>	<p>\$500 per Covered Person, not to exceed \$1,500 for all Covered Persons in a family.</p>



Payment Term And Description	Amounts
Occurrence Deductible.	
<b>Per Occurrence Deductible</b>	
<p>The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Per Occurrence Deductible.</li> <li>• The Eligible Expense.</li> </ul>	<p>When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.</p>
<b>Out-of-Pocket Maximum</b>	
<p>The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> <li>• Any charges for non-Covered Health Services.</li> <li>• Charges that exceed Eligible Expenses.</li> <li>• Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum.</li> </ul>	<p>\$2,500 per Covered Person, not to exceed \$5,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p> <p>The Out-of-Pocket Maximum includes the Per Occurrence Deductible.</p>
<b>Copayment</b>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment.</li> <li>• The Eligible Expense.</li> </ul>	

Payment Term And Description	Amounts
<p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
<p><b>Coinsurance</b></p>	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>1. Ambulance Services</b>			
<b>Prior Authorization Recommendation</b>  In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you should obtain authorization as soon as possible prior to transport so that we can determine whether the service meets the definition of a Covered Health Service.			
<b>Emergency Ambulance</b>  <b>Non-Emergency Ambulance</b> Ground or air ambulance, as we determine appropriate.	<i>Ground Ambulance:</i> 80%  <i>Air Ambulance:</i> 80%  <i>Ground Ambulance:</i> 80%  <i>Air Ambulance:</i> 80%	Yes  Yes  Yes  Yes	Yes  Yes  Yes  Yes
<b>2. Congenital Heart Disease Surgeries</b>			
Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .	80% for services provided with a referral from your Primary Physician	Yes	Yes, after the Per Occurrence Deductible of \$150 per Inpatient Stay is satisfied
<b>3. Dental Services - Accident Only</b>			
	80%	Yes	Yes
<b>4. Diabetes Services</b>			
<b>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</b>  <b>Diabetes Self-Management Items</b>	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .  Depending upon where the Covered Health Service is		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i> .	provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
<b>5. Durable Medical Equipment</b>			
<p>Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums.</p> <p>You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.</p>	80%	Yes	Yes
<b>6. Emergency Health Services - Outpatient</b>			
<p><b>Note:</b> If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 48 hours or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided.</p>	100% after you pay a Copayment of \$300 per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	Yes	No
<b>7. Hearing Aids for Adults</b>			
<p>Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.</p>	80%	Yes	Yes
<b>8. Hearing Aids for Minor Children</b>			
Depending upon where the Covered Health Service is			

Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>9. Home Health Care</b>			
<p>Limited to 60 visits per year. One visit equals up to four hours of skilled care services.</p> <p>This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p>	80%	Yes	Yes
<b>10. Hospice Care</b>			
Bereavement support services are limited to \$1,150 during the 12-month period following the Covered Person's death.	80%	Yes	Yes
<b>11. Hospital - Inpatient Stay</b>			
	80% for services provided with a referral from your Primary Physician	Yes	Yes, after the Per Occurrence Deductible of \$150 per Inpatient Stay is satisfied
<b>12. Lab, X-Ray and Diagnostics - Outpatient</b>			
<b>Lab Testing - Outpatient:</b> <b>X-Ray and Other Diagnostic Testing - Outpatient:</b>	80%	Yes	Yes
<b>X-Ray and Other Diagnostic Testing - Outpatient:</b>	80%	Yes	Yes
<b>13. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>			
	100% after you pay a Copayment of \$150 per service	Yes	No
<b>14. Mental Health Services</b>			
	<i>Inpatient</i>  <b>Non-Biologically Based Mental Illness or Mental Disorders</b>		



Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>80% for services provided by your Primary Physician or by a Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife</p> <p>80% for services provided with a referral from your Primary Physician</p>	Yes	Yes
<b>19. Physician's Office Services - Sickness and Injury</b>			
<p>In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> <li>• Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.</li> <li>• Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.</li> <li>• Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.</li> <li>• Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>.</li> <li>• Outpatient surgery procedures described under <i>Surgery - Outpatient</i>.</li> </ul>	<p>100% after you pay a Copayment of \$25 per visit for services provided by your Primary Physician or by a Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife</p> <p>100% after you pay a Copayment of \$50 per visit for services provided with a referral from your Primary Physician</p>	Yes	No

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> <li>Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>.</li> </ul>			
<b>20. Pregnancy - Maternity Services</b>			
<b>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</b>			
	Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
<b>21. Preventive Care Services</b>			
<b>Physician office services</b>	100% for services provided by your Primary Physician or by a Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife  100% for services provided with a referral from your Primary Physician	No	No
<b>Lab, X-ray or other preventive tests</b>	100% for services provided by your Primary Physician or by a Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife  100% for services provided with a referral from your	No	No



Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>Additional Preventive Care Services</b>	Primary Physician  100% for services provided by your Primary Physician or by a Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife  100% for services provided with a referral from your Primary Physician	No	No
<b>22. Prosthetic Devices</b>			
Limited to \$2,500 per year. Benefits are limited to a single purchase of each type of prosthetic device every three years.  Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998</i> and for prosthetic arms, legs, feet and hands.	80%	Yes	Yes
<b>23. Reconstructive Procedures</b>			
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			
<b>24. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</b>			
Limited per year as follows: <ul style="list-style-type: none"> <li>• 20 visits of physical therapy.</li> <li>• 20 visits of occupational therapy.</li> <li>• 20 Manipulative Treatments.</li> <li>• 20 visits of speech therapy.</li> </ul>	100% after you pay a Copayment of \$50 per visit for Manipulative Treatment services provided with a referral from your Primary Physician  100% after you pay a	Yes	No

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> <li>20 visits of pulmonary rehabilitation therapy.</li> <li>36 visits of cardiac rehabilitation therapy.</li> <li>30 visits of post-cochlear implant aural therapy.</li> <li>20 visits of cognitive rehabilitation therapy.</li> </ul>	Copayment of \$25 per visit for all other rehabilitation services		
<b>25. Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>			
	80% for services provided by your Primary Physician or by a Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife  80% for services provided with a referral from your Primary Physician	Yes	Yes
<b>26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>			
Limited to 60 days per year.	80%	Yes	Yes
<b>27. Substance Use Disorder Services</b>			
	<i>Inpatient</i> 80%  <i>Outpatient</i> 100% after you pay a Copayment of \$50 per visit	Yes   Yes	Yes   No

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>28. Surgery - Outpatient</b>			
	80% for services provided by your Primary Physician or by a Network obstetrician, gynecologist or advanced practice nurse who is a certified nurse midwife  80% for services provided with a referral from your Primary Physician	Yes	Yes, after the Per Occurrence Deductible of \$75 per date of service is satisfied
<b>29. Therapeutic Treatments - Outpatient</b>			
	80%	Yes	Yes
<b>30. Transplantation Services</b>			
<b>Prior Authorization Recommendation</b>  You should obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center) so that we can determine whether the service meets the definition of a Covered Health Service.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>31. Urgent Care Center Services</b>			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:  <ul style="list-style-type: none"> <li>• Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.</li> <li>• Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics -</i></li> </ul>	100% after you pay a Copayment of \$75 per visit	Yes	No

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i></p> <ul style="list-style-type: none"> <li>• Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i></li> <li>• Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i></li> <li>• Outpatient surgery procedures described under <i>Surgery - Outpatient.</i></li> <li>• Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i></li> </ul>			
<b>32. Vision Examinations</b>			
Limited to 1 exam every 2 years.	100% after you pay a Copayment of \$25 per visit	Yes	No
<b>Additional Benefits Required By Colorado Law</b>			
<b>33. Autism Spectrum Disorders</b>			
<p><b>Prior Authorization Recommendation</b></p> <p>Depending upon where the Covered Health Service is provided, prior authorization recommendations will be the same as those stated under the applicable Covered Health Service category in the Schedule of Benefits.</p>			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>		
<b>34. Cleft Lip and Cleft Palate Treatment</b>			
<p><b>Prior Authorization Recommendation</b></p> <p>You should obtain prior authorization as soon as reasonably possible of the need for treatment begins so that we can determine whether the service meets the definition of a Covered Health Service.</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>35. Clinical Trials</b>			
<b>Prior Authorization Recommendation</b>			
You should obtain prior authorization as soon as the possibility of participation in a clinical trial arises so that we can determine whether the service meets the definition of a Covered Health Service.			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>36. Colorectal Cancer Screening</b>			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . The screening for the early detection of colorectal cancer and adenomatous polyps is not subject to any deductibles.		
<b>37. Hospitalization and General Anesthesia for Dental Procedures for Children</b>			
<b>Prior Authorization Recommendation</b>			
You should obtain prior authorization as soon as reasonably possible of the need for treatment so that we can determine whether the service meets the definition of a Covered Health Service.			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>38. Phenylketonuria (PKU) Testing and Treatment</b>			
<b>Prior Authorization Recommendation</b>			
Depending upon where the Covered Health Service is provided, prior authorization recommendations will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			
<b>39. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)</b>			
<b>Prior Authorization Recommendation</b>			
You should obtain prior authorization five business days before receiving or as soon as reasonably possible so that we can determine whether the service meets the definition of a Covered Health Service.			
Limited per year as follows:  Care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered 20 visits each for physical, occupational and speech therapy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	100% after you pay a Copayment of \$25 per visit	Yes	No
<b>40. Telemedicine</b>			
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			

## Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. You are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- Health care services provided at a Network Facility, including services provided by a non-Network provider are to be provided to you at no greater cost than if services were obtained by a network provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

Please refer to [www.myuhc.com](http://www.myuhc.com) or call the telephone number for *Customer Care* listed on your ID card for more information.

## Provider Network

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

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

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

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

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

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

## Designated Facilities and Other Providers

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

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

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

## **Health Services from Non-Network Providers**

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



# Certificate of Coverage

## UnitedHealthcare Insurance Company

### Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

You can review the Policy at the office of the Enrolling Group during regular business hours. The *Group Policy* describes the contractual obligations agreed to between us and the Enrolling Group.

### Changes to the Document

Changes to the Policy and this *Certificate* must be in writing. We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages. For details, see *Amendments to the Policy* in *Section 8: General Legal Provisions*.

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

### Other Information You Should Have

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

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

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

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

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an

insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the *Office of the Commissioner of Insurance* within the *Department of Regulatory Agencies*.

# Introduction to Your Certificate

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

## How to Use this Document

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

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

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

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

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

## Information about Defined Terms

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

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

## Don't Hesitate to Contact Us

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

## Access Plan

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

# Your Responsibilities

## Be Enrolled and Pay Required Contributions

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

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

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

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

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

## Decide What Services You Should Receive

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

## Choose Your Physician

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

## Obtain Prior Authorization

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

## Pay Your Share

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

## **Pay the Cost of Excluded Services**

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

## **Show Your ID Card**

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

## **File Claims with Complete and Accurate Information**

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

## **Use Your Prior Health Care Coverage**

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

# Our Responsibilities

## Determine Benefits

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

We have the discretion to do the following:

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

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

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

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

## Pay Network Providers

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

## Pay for Covered Health Services Provided by Non-Network Providers

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

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

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. Health care services provided at a Network facility, including services provided by a Non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

## **Offer Health Education Services to You**

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

# Certificate of Coverage Table of Contents

<b>Section 1: Covered Health Services .....</b>	<b>9</b>
<b>Section 2: Exclusions and Limitations.....</b>	<b>30</b>
<b>Section 3: When Coverage Begins .....</b>	<b>43</b>
<b>Section 4: When Coverage Ends .....</b>	<b>47</b>
<b>Section 5: How to File a Claim .....</b>	<b>51</b>
<b>Section 6: Questions, Complaints and Appeals .....</b>	<b>53</b>
<b>Section 7: Coordination of Benefits .....</b>	<b>56</b>
<b>Section 8: General Legal Provisions .....</b>	<b>61</b>
<b>Section 9: Defined Terms .....</b>	<b>68</b>



# Section 1: Covered Health Services

## Benefits for Covered Health Services

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

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

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

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

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

### 1. Ambulance Services

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

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

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

## **2. Congenital Heart Disease Surgeries**

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

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

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

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

## **3. Dental Services - Accident Only**

Dental services when all of the following are true:

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

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

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

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

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

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

## **4. Diabetes Services**

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

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

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

### **Diabetic Self-Management Items**

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

## **5. Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

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

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.

- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

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

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

Benefits are available for repairs and replacement, except that:

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

## **6. Emergency Health Services - Outpatient**

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

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

Health care services provided at a Network facility, including services provided by a non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider.

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

## **7. Hearing Aids for Adults**

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) for adults age 18 and older. Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

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

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

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

## **8. Hearing Aids for Minor Children**

Hearing aids for a minor child, which is a person under the age of 18 years, who has a hearing loss that has been verified by a licensed Physician and by an audiologist are covered. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following:

- Initial hearing aids and replacement hearing aids not more frequently than every five years;
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.
- "Hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" shall include any parts or ear molds.

## 9. Home Health Care

Home health care services received from a Home Health Agency that are both of the following:

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

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required. Home health services are to be covered when services are necessary as alternatives to hospitalization, or in place of hospitalization. Prior hospitalization is not required.

Home health care visits may be included but are not limited to:

- Skilled nursing visits;
- Home health aide services visits that provide supportive care in the home which are reasonable and necessary to the member's illness or Injury;
- Physical, occupational, or speech therapy and audiology services that is provided on a per visit basis;
- Respiratory and inhalation therapy;
- Nutrition counseling by a nutritionist or dietitian;
- Medical supplies, Durable Medical Equipment; and
- Infusion therapy medications and supplies and laboratory services as prescribed by a provider to the extent such services would be covered by us had the member remained in the hospital, rehabilitation or Skilled Nursing Facility.

"Medical social services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a Physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

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

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

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

## 10. Hospice Care

Hospice services are covered for members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six months or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the member's interdisciplinary team, which includes, but is not limited to, the member, the member's Physician, a registered nurse, a social worker and a spiritual caregiver.

Benefits are available when hospice services are received from a hospice agency that is licensed and regulated by the *Colorado Department of Public Health and Environment*.

Hospice services include:

- Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse and nursing services delegated to other assistants.
- Bereavement services (limited to a maximum of \$1,150 during the 12-month period following death).
- Social services/counseling services.
- Medical direction.
- Volunteer services.
- Drugs and biologicals.
- Prosthesis and orthopedic appliances.
- Oxygen and respiratory supplies.
- Diagnostic testing.
- Rental or purchase of durable equipment.
- Transportation.
- Physician services.
- Nutritional counseling by a nutritionist or dietitian.
- Medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions.
- Physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the member to maintain activities of daily living and basic functional skills.

Covered hospice services are available in the home on a 24-hour basis during periods of crisis, when a member requires continuous care to achieve palliation or management of acute medical symptoms.

Home is defined as a place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. Inpatient hospice services are provided in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the member ("respite care"). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or Injuries.

## **11. Hospital - Inpatient Stay**

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

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

## **12. Lab, X-Ray and Diagnostics - Outpatient**

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

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

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

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

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

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

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

Benefits under this section include:

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

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

## **14. Mental Health Services**

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility, including services to treat Biologically Based Mental Illness and Mental Disorders.

Benefits include treatment of Mental Illness whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

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

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

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

### **Special Mental Health Programs and Services**

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

## **15. Neurobiological Disorders - Autism Spectrum Disorder Services**

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

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.



This section describes only the psychiatric component of treatment for Autism Spectrum Disorders for which benefits are not subject to any age limit. Medical treatment of Autism Spectrum Disorders for Enrolled Dependent children from birth through 18 years of age is a Covered Health Service for which Benefits are available under *Additional Benefits Required by Colorado Law - Autism Spectrum Disorders* below. Medical treatment of Autism Spectrum Disorders for all other Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this *Certificate*.

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Prescription drug products when prescribed by a licensed Physician.
- Individual, family, therapeutic group, and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

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

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

## **16. Ostomy Supplies**

Benefits for ostomy supplies are limited to the following:

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

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

## **17. Pharmaceutical Products - Outpatient**

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

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

## **18. Physician Fees for Surgical and Medical Services**

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

## **19. Physician's Office Services - Sickness and Injury**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

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

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

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

Benefits under this section include allergy injections.

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

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

## **20. Pregnancy - Maternity Services**

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

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include genetic counseling and testing when there is a reasonable probability that, because of family history, parental age, or exposure to an agent which might cause birth defects or cancer in the fetus, the results will affect medical decisions involving the existing Pregnancy. Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

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

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

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

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

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

## **21. Preventive Care Services**

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

### **Physician office services:**

- Routine physical examinations.
- Well-baby and well-child care.
- Immunizations. Immunization deficient children are not bound by "recommended ages".
- Cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the *United States Department of Health and Human Services*.
- Hearing screening.
- Child Health Supervision Services.

### **Lab, X-ray or other preventive tests:**

- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening, including:
  - One screening per year for Covered Persons age 50 and over.
  - One screening per year for Covered Persons age 40 and over who are in high risk categories, as determined by a Physician.

- Bone mineral density tests.

### **Additional preventive care services:**

Covered preventive care services, in accordance with the A or B recommendations of the Task Force, include the following services:

- Alcohol misuse screening and behavioral counseling interventions for adults by your Primary Physician.
- Cervical cancer screening.
- Breast cancer screening with mammography per calendar year or contract year. Please refer to your *Schedule of Benefits* to determine whether your Benefits are provided on a calendar year or contract year basis.
- Cholesterol screening for lipid disorders.
- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps.
- Colorectal cancer screening coverage for members in accordance with A or B recommendations of the Task Force.
- Colorectal cancer screening coverage for members who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a participating provider.
- Childhood immunizations pursuant to the schedule established by the ACIP.
- Influenza vaccinations pursuant to the schedule established by the ACIP.
- Pneumococcal vaccinations pursuant to the schedule established by the ACIP.
- Tobacco use screening of adults and tobacco cessation interventions by your Primary Physician.

"ACIP" means the advisory committee on immunization practices to the *Centers for Disease Control and Prevention* in the *Federal Department of Health and Human Services*, or any successor entity.

"A recommendation" means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

"B recommendation" means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

"Task force" means the *U.S. Preventive Services Task Force*, or any successor organization, sponsored by the *Agency for Healthcare Research and Quality*, the *Health Services Research Arm of the Federal Department of Health and Human Services*.

## **22. Prosthetic Devices**

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

- Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria and are not subject to the Durable Medical Equipment Benefit limits. Bionic,

myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria. Benefits are available for repairs and replacement, except that there are no Benefits for:

- Repairs due to misuse, malicious damage or gross neglect, and
  - Replacement due to misuse, malicious damage or gross neglect or for lost prosthetic devices.
- Artificial arms, legs, feet and hands.
  - Artificial face, eyes, ears and nose.
  - Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

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

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

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

Benefits are available for repairs and replacement, except that:

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

### **23. Reconstructive Procedures**

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

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

### **24. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.

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

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

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

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

## **25. Scopic Procedures - Outpatient Diagnostic and Therapeutic**

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

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

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

Benefits under this section include:

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

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

## **26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

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

- Supplies and non-Physician services received during the Inpatient Stay.

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

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

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

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

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

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

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

## **27. Substance Use Disorder Services**

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

Benefits include treatment of substance use whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice system.

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

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

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

### **Special Substance Use Disorder Programs and Services**

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

## **28. Surgery - Outpatient**

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

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

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

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Health care services provided at a Network facility, including services provided by a non-Network provider are to be provided to you at no greater cost than if the services were obtained by a Network provider.

## **29. Therapeutic Treatments - Outpatient**

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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



Benefits under this section include:

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

### **30. Transplantation Services**

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

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

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

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

### **31. Urgent Care Center Services**

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

### **32. Vision Examinations**

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

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

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

## **Additional Benefits Required By Colorado Law**

### **33. Autism Spectrum Disorders**

Benefits are provided for Covered Health Services for an Enrolled Dependent who is under the age of 19 and who has been diagnosed with Autism Spectrum Disorders. Benefits are provided for the services listed below. Benefits for psychiatric treatment for Autism Spectrum Disorders (including Applied Behavioral Analysis) are described under *Neurobiological Disorders - Autism Spectrum Disorder Services*.

- Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorders; and
- Treatment of Autism Spectrum Disorders through speech therapy, occupational therapy, and physical therapy. The visit limits described under *Rehabilitative Services - Outpatient Therapy and Manipulative Treatment* in this *Certificate* for speech therapy, occupational therapy, and physical therapy do not apply to *Autism Spectrum Disorders*.

Benefits are limited to treatment that is prescribed by the Covered Person's treating Physician in accordance with a treatment plan. The treatment plan must include, but is not limited to, the following:

- The diagnosis.
- The proposed treatment by types.
- The frequency and duration of treatment.
- The anticipated outcomes stated as goals.
- The frequency with which the treatment plan will be updated.
- The signature of the treating Physician.
- Evaluation and assessment services.

### **34. Cleft Lip and Cleft Palate Treatment**

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

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

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

### **35. Clinical Trials and Studies**

Routine patient care costs that a member receives during a Clinical Trial will be covered if:

- The member's provider recommends participation in the Clinical Trial after determining that participation in the Clinical Trial has the potential to provide a therapeutic health benefit to the member;
- The Clinical Trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding Clinical Trials, as amended;
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;

- Prior to participation in a Clinical Trial or study, the member has signed a statement of consent indicating that the member has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the Clinical Trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the member's health benefit plan, and all out-of-network rates will apply; and
- The member suffers from a condition that is disabling, progressive, or life-threatening.

Coverage does not include:

- Any portion of the Clinical Trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- Extraneous expenses related to participation in the Clinical Trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
- Costs for the management of research relating to the Clinical Trial or study; or
- Health care services that, except for the fact that they are being provided in a Clinical Trial, are otherwise specifically excluded from coverage under the member's health plan.

"Clinical Trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

"Routine Patient Care Cost" means all items and services that are a benefit under a health coverage plan that would be covered if the member were not involved in either the experimental or the control arms of a Clinical Trial; except the investigational item or service itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in Clinical Trials that include items or services that are typically provided absent a Clinical Trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

### **36. Colorectal Cancer Screening**

Coverage for the early detection of colorectal cancer and adenomatous polyps for those members who are asymptomatic, average risk adults who are 50 years of age or older and members who are at high risk for colorectal cancer, including Covered Persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a Network provider.

The following tests are covered as determined by a Network provider that detect adenomatous polyps or colorectal cancer: Modalities that are currently included in an "A recommendation" or a "B recommendation" by the Task Force.

- "A recommendation" means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the Task Force:
  - Found good evidence that the preventive health care service improves important health outcomes; and
  - Concluded that the benefits of the preventive health care service substantially outweigh its harms.
- "B recommendation" means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the Task Force:
  - Found at least fair evidence that the preventive health care service improves important health outcomes; and
  - Concluded that the benefits of the preventive health care service outweigh its harms.

"Task force" means the *U.S. Preventive Services Task Force*, or any successor organization, sponsored by the *Agency for Healthcare Research and Quality*, the *Health Services Research Arm of the Federal Department of Health and Human Services*.

The screening for the early detection of colorectal cancer and adenomatous polyps is not subject to any deductibles. If additional therapeutic or surgical services are required during the screening as a result of screening findings, the Outpatient Surgery Copayment, Coinsurance and deductible will apply.

### **37. Hospitalization and General Anesthesia for Dental Procedures for Children**

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

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

### **38. Phenylketonuria (PKU) Testing and Treatment**

Testing for phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. Medical foods, for the purpose of this Benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical foods are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects.

Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not limited to, the following diagnosed conditions: phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent Medically Necessary, medical foods for home use for which a participating Physician has issued a written, oral or electronic prescription. Benefits for medical foods are described under the *Outpatient Prescription Drug Rider*.

The maximum age to receive this Benefit is 21, except that the maximum age for women who are of child-bearing age is 35.

### **39. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)**

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

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

### **40. Telemedicine Services**

Covered Health Services received through telemedicine if:

- The Colorado county in which you reside has the technology necessary for the provision of telemedicine; and
- In-person care from a Network provider is not available to you within your geographic area.

Face-to-face contact is not required between you and your provider for services appropriately provided through telemedicine, subject to all terms and conditions of the Policy.

For purposes of this Benefit, "telemedicine" is the delivery of medical services and diagnosis, consultation or treatment using interactive audio, interactive video or interactive data communication. Consultation provided by a provider using telephone or facsimile machine is not telemedicine.

## Section 2: Exclusions and Limitations

### How We Use Headings in this Section

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

### We do not Pay Benefits for Exclusions

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

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

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

### Benefit Limitations

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

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

### A. Alternative Treatments

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

### B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as described under *Hospitalization and General*

*Anesthesia for Dental Procedures for Children and Cleft Lip and Cleft Palate Treatment in Section 1: Covered Health Services.*

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

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.
- As described under *Hospitalization and General Anesthesia for Dental Procedures for Children* in *Section 1: Covered Health Services*.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

### **C. Devices, Appliances and Prosthetics**

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
  - Blood pressure cuff/monitor.
  - Enuresis alarm.
  - Non-wearable external defibrillator.

- Trusses.
  - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech.
  6. Oral appliances for snoring.
  7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
  8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

#### **D. Drugs**

1. Prescription drug products for outpatient use that are filled by a prescription order or refill, except as described under *Reproductive Services Products* and *Tobacco Cessation Products* described in *Section 1: Covered Health Services*.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

#### **E. Experimental or Investigational or Unproven Services**

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

- The drug has been approved by the *U.S. Food and Drug Administration (FDA)* as an "investigational new drug for treatment use."
- If it is a drug classified by the *National Cancer Institute* as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in *FDA* regulations.
- The drug has been approved by the *FDA* for use in the treatment of cancer but has not been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.

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



## **F. Foot Care**

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

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

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

## **G. Medical Supplies**

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Compression stockings.
  - Ace bandages.
  - Gauze and dressings.
  - Urinary catheters.

This exclusion does not apply to:

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

## **H. Mental Health**

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

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

## **I. Neurobiological Disorders - Autism Spectrum Disorders**

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

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
3. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.
6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
7. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder for an Enrolled Dependent 19 years of age or older.
8. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
  - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
  - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
  - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

## **J. Nutrition**

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition, except for the first 31 days of life. Benefits for medical foods are described under the *Outpatient Prescription Drug Rider*.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

## **K. Personal Care, Comfort or Convenience**

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters and dehumidifiers.

- Batteries and battery chargers.
- Breast pumps.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

## **L. Physical Appearance**

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.

- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
  3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
  4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
  5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
  6. Wigs regardless of the reason for the hair loss.

## **M. Procedures and Treatments**

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except:
  - As described under *Rehabilitation Services - Outpatient Therapy* in *Section 1: Covered Health Services*; or
  - As required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.
  - Therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity; or
  - As described under *Cleft Lip and Cleft Palate Treatment* in *Section 1: Covered Health Services*.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.

11. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
12. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
13. Surgical and non-surgical treatment of obesity.
14. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures in Section 1: Covered Health Services*.
16. In vitro fertilization regardless of the reason for treatment.

## **N. Providers**

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

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

This exclusion does not apply to mammography.

## **O. Reproduction**

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

## **P. Services Provided under another Plan**

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

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

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

## **Q. Substance Use Disorders**

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

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

## **R. Transplants**

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

## **S. Travel**

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

## T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## U. Vision and Hearing

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

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

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

This exclusion does not apply to hearing aids for minor children as described under *Hearing Aids for Minor Children*.

## V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
  - Medically Necessary.



- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
  - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
    - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption. This exclusion does not apply to treatment for Injuries resulting from a Covered Person's casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding.
    - Related to judicial or administrative proceedings or orders except as described under *Substance Use Disorder Services*.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials and Studies* in *Section 1: Covered Health Services*.
    - Required to obtain or maintain a license of any type.
  3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
  4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
  5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
  6. In the event a non-Network 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.
  7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
  8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
  9. Autopsy.
  10. Foreign language and sign language services.
  11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

12. Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. For purposes of this exclusion, "pain management" means a pain state in which the cause of the pain cannot be removed and which, in the generally accepted course of medical practice, no relief or cure of the cause of pain is possible,

or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area.

13. Consultation by a provider by telephone or facsimile.

## Section 3: When Coverage Begins

### How to Enroll

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

### If You Are Hospitalized When Your Coverage Begins

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

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

### Who is Eligible for Coverage

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

#### Eligible Person

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

Eligible Persons must reside within the United States.

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

#### Dependent

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

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

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

### When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents. When you enroll you must submit all enrollment forms and any required payment to the Enrolling Group. The Enrolling Group is responsible for forwarding all enrollment information to us and for making required payment to us.

## **Initial Enrollment Period**

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

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

## **Open Enrollment Period**

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

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

## **Dependent Child Special Open Enrollment Period**

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

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

## **New Eligible Persons**

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

## **Adding New Dependents**

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

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

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

Newborns are covered for the first 31 days of life. If a specific Premium is required to provide coverage for the newborn, you must submit a completed enrollment form to us prior to the expiration of the 31-day period for coverage to continue beyond the first 31 days of life. If no additional Premium is required to

provide coverage for the newborn, you are required to submit a completed enrollment form to us prior to the expiration of the 31-day period.

## Special Enrollment Period

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

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

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

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

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

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

- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

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

## Section 4: When Coverage Ends

### General Information about When Coverage Ends

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

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

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

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

### Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended. See the *Notice of Conversion* provision in *Section 8: General Legal Provisions*.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." The Subscriber or the Enrolling Group is responsible for providing us written notice to end your coverage.

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

## Other Events Ending Your Coverage

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

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

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

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

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

## Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if the Enrolled Dependent child depends mainly on the Subscriber for support.

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

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

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

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

## Extended Coverage If You Are Hospitalized

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

## Continuation of Coverage and Conversion

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

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



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

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

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

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

## **Qualifying Events for Continuation Coverage under State Law**

To qualify for continuation coverage under state law, the Covered Person must meet the criteria below:

- The Covered Person was enrolled, for a period of at least six months immediately prior to termination of coverage, for coverage under the Policy or under any other group plan that was replaced by the Policy that provided Benefits similar to Benefits under the Policy.
- The Covered Person is not enrolled in Medicare or Medicaid.

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group.
- Reduction in the Subscriber's hours to less than 40 hours a week as a result of economic conditions.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.

Continuation of coverage is subject to the Policy (or a successor policy) remaining in force and the Premium being paid according to the terms of the Policy. If the Covered Person's coverage terminated due to one of the qualifying events listed above, he or she is entitled to continuation coverage under state law.

## **Notification Requirements and Election Period for Continuation Coverage under State Law**

The Enrolling Group will provide you with written notification of the right to continuation coverage within 10 days of when coverage ends under the Policy. You must elect continuation coverage within:

- 30 days after the qualifying event, if the plan administrator provides written notice of the right to continue; or
- 60 days after the qualifying event occurs, if the plan administrator does not provide written notice of the right to continue.

You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

## **Terminating Events for Continuation Coverage under State Law**

Continuation coverage under the Policy will end on the earliest of the following dates:

- 18 months from the date your continuation began.
- The date you no longer live or work within the Service Area.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is obtained under any other group health plan which does not contain a preexisting limitation or exclusion for any condition which is covered under the Policy.
- The date you become covered by Medicare.
- The date you become covered by Medicaid.
- The date the Policy ends.

## **Conversion**

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- If the Policy under which you are entitled is issued to an Enrolling Group that has 50 or fewer employees, you may also apply for conversion coverage without furnishing evidence of insurability if the entire Policy is terminated and not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

## Section 5: How to File a Claim

### If You Receive Covered Health Services from a Network Provider

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

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

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

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

### Required Information

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

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

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

### Payment of Benefits

We will pay Benefits within 45 days for paper claims and 30 days for electronic claims after we receive your request for payment that includes all required information.

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

Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

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

## **Section 6: Questions, Complaints and Appeals**

### **What to Do if You Have a Question**

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

### **What to Do if You Have a Complaint**

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

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

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

### **How to Appeal a Claim Decision**

#### **Post-service Claims**

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

#### **Pre-service Requests for Benefits**

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

#### **How to Request an Appeal**

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

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or 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 by a Physician 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.

## Appeals Determinations

### Pre-service Requests for Benefits and Post-service Claim Appeals

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

You will be provided written or electronic notification of the decision on your 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 no later than 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of pre-service request, if you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your second level appeal request must be submitted to us within 30 days from receipt of the first level appeal decision. The second level appeal review meeting, by either a health care professional or review panel of health care professionals, as appropriate, will be conducted within 60 days of receipt of the request for a voluntary second level review. These reviewer(s) will not have a direct financial interest in the outcome of the review. You will be notified in writing at least 20 days in advance of the date of the review meeting. You will be notified in writing of the decision within seven days of completion of the review meeting.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision no later than 30 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims as identified above, if you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your second level appeal request must be submitted to us within 30 days from receipt of the first level appeal decision. The second level appeal review meeting, by either a health care professional or review panel of health care professionals, as appropriate, will be conducted within 60 days of receipt of the request for a voluntary second level review. These reviewer(s) will not have a direct financial interest in the outcome of the review. You will be notified in writing at least 20 days in advance of the date of the review meeting. You will be notified in writing of the decision within seven days of completion of the review meeting.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That 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.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

## **Independent External Review Program**

After you exhaust at least one level of the appeal process, if we make a final determination to deny Benefits, you may choose to participate in the independent external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits unless the member presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.

You or your representative must file a request for independent external review no later than 60 calendar days after you have received notification of the appeal decision. Your written request for an independent external review must include a completed external review request form specified by the *Office of the Commissioner of Insurance* as well as a signed consent authorizing us to disclose your medical records. New information may be submitted with the request if it is significantly different from the information provided or considered during the internal appeal process.

We will submit a copy of your request to the *Office of the Commissioner of Insurance*, who will select an independent external review entity. The independent external review entity will determine whether to uphold or reverse our appeal decision within 30 working days of receipt of the request for external review. For expedited reviews, the independent external review entity will determine whether to uphold or reverse our appeal decision within seven working days of receipt of the request for external review.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

## Section 7: Coordination of Benefits

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

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

### When Coordination of Benefits Applies

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

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

### Definitions

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

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
  - 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
  - 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after



those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

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

## **Order of Benefit Determination Rules**

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

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

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

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

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

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

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
  - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
  - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
    - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
    - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
    - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

- (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
  - (a) The Plan covering the Custodial Parent.
  - (b) The Plan covering the Custodial Parent's spouse.
  - (c) The Plan covering the non-Custodial Parent.
  - (d) The Plan covering the non-Custodial Parent's spouse.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

## **Effect on the Benefits of This Plan**

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

## **Right to Receive and Release Needed Information**

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

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

## **Payments Made**

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

## **Right of Recovery**

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

## **When Medicare is Secondary**

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

## Section 8: General Legal Provisions

### Your Relationship with Us

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

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

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

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

### Our Relationship with Providers and Enrolling Groups

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

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

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

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

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

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

## **Your Relationship with Providers and Enrolling Groups**

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

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

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

## **Notice**

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

## **Notice of Continuation**

In the event of termination of employment, the Enrolling Group will give eligible Subscribers written notice that continuation of coverage under the Enrolling Group's Policy is available. The Enrolling Group will give notice of continuation within 10 days of the date coverage would end. The notice will include the following:

- Notice of the Subscriber's right to continue group coverage.
- The amount of the payments needed to continue coverage.
- Where, when, and how to make payments.

## **Notice of Conversion**

In the event of termination of coverage, a Subscriber who is entitled to make application for conversion coverage will be given written notice of the conversion privilege at least 15 days prior to the expiration of the 31-day conversion period. If the Subscriber is not given notice of his/her conversion rights, the Subscriber will have an additional period within which to make application. This additional period will expire 15 days after the Subscriber has been given the written notice, but in no event will the additional period be continued for more than 60 days after the expiration of the 31-day conversion period established by the Policy. Written notice presented by the Enrolling Group or mailed by the Enrolling Group to the last known address of the Subscriber (as furnished to the Enrolling Group), will constitute the giving of notice for the purpose of this provision. If the Enrolling Group is a small employer group, as defined by Colorado law, we are responsible for providing notice of conversion rights.

## Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years. No statement will be used to void or reduce coverage under the Policy or be used in defense of a legal action, unless it is contained in a written application.

## Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

## Incentives to You

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

## Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any Annual Deductible or taken into account in determining your Copayments or Coinsurance.

## Interpretation of Benefits

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

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

- Make factual determinations related to the Policy and its Benefits.

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

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

## **Administrative Services**

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

## **Amendments to the Policy**

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

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

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

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

## **Information and Records**

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

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

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



for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

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

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

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

## **Examination of Covered Persons**

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

## **Workers' Compensation not Affected**

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

## **Subrogation and Reimbursement**

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

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

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

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

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.

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

## Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## Limitation of Action

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

## Entire Policy

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

## Section 9: Defined Terms

**A Recommendation** - means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

**B Recommendation** - means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

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

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

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

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

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

**Applied Behavioral Analysis** - includes the use of behavioral analytic methods and research findings to change socially important behaviors in meaningful ways.

**Autism Spectrum Disorders or (ASD)** - includes the following neurobiological disorders: *autistic disorder; Asperger's Disorder* and *Atypical Autism* as a diagnosis with *Pervasive Development Disorder Not Otherwise Specified (PDDNOS)*, as defined in the most recent addition of the *Diagnostic and Statistical Manual of Mental Disorders*, at the time of the diagnosis.

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

**Biologically Based Mental Illnesses** - the following conditions as described in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.

**Child Health Supervision Services** - those preventive services and immunizations required to be provided to dependent children up to age 13 as follows:

- 0 - 12 months: One newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours following delivery; six well-child visits; one PKU testing.
- 13 - 35 months: Three well-child visits.

- 3 - 6 years: Four well-child visits.
- 7 - 12 years: Four well-child visits.
- 0 - 12 years: Immunizations. Immunization deficient children are not bound by "recommended ages".

**Clinical Trial** - an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

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

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

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

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

- The applicable Copayment.
- The Eligible Expense.

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

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

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

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

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

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

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

- A natural child.
- A stepchild.

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

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

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

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

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

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

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

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

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

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

**Disability or Disabled** - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation and a Dependent's inability to perform the normal activities of a person of like age and sex.

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

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

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

- They must be mentally competent to consent to contract.
- They must be financially interdependent.

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

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

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

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, 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 (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Please refer to [www.myuhc.com](http://www.myuhc.com) or call the telephone number for *Customer Care* listed on your ID card for more information.

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

**Emergency** - a sudden and, at the time, unexpected onset of a health condition that a prudent lay person would assume requires immediate attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

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

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

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

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use except that Benefits are provided for Prescription Drug Products that have been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials and Studies in Section 1: Covered Health Services*.
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

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

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

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

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



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

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

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

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

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

**Medically Necessary** - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

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

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

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

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

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

**Mental Disorder** - means post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient day treatment, and inpatient basis, exclusive of residential treatment. Mental disorders will not be subject to the limitations of Mental Health Services as described above.

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

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

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

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

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

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

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

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

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

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

**Per Occurrence Deductible** - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Routine Patient Care Costs** - all items and services that would be covered if the Covered Person were not involved in either the experimental or the control arms of a Clinical Trial; except the investigational item or service itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any Covered Person in the trial; routine costs in Clinical Trials that include items or services that are typically provided absent a Clinical Trial; items or services required solely for the provision of the investigational items or services; the clinically appropriate monitoring of the effects of the item or service; the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

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

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

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

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

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

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Task Force** - means the *U.S. Preventive Services Task Force* or any successor organization, sponsored by the *Agency for Healthcare Research and Quality*, the *Health Services Research Arm* of the federal *Department of Health and Human Services*.

**The Advisory Committee on Immunization Practices (ACIP)** - means the advisory committee on immunization practices to the *Centers for Disease Control and Prevention* in the *Federal Department of Health and Human Services*, or any successor entity.

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

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

**Unproven Service(s)** - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

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

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

Please note:

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

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

## Standard Section Names

As required by Colorado Regulation 4-2-34, effective January 1, 2012, the purpose of the chart below is to:

- Provide a standardized format for section names in Policy forms issued by health carriers.
- Provide a directory cross-referencing the standard section names (left column) with those section names that currently appear in UnitedHealthcare's Policy forms (right column).

<b>Standard Section Names as required by Colorado Regulation 4-2-34</b>	<b>UnitedHealthcare Current Section Names</b>
Schedule of Benefits (Who Pays What)	Schedule of Benefits
Title Page (Cover Page)	Title Page (Cover Page)
Contact Us	<ul style="list-style-type: none"> <li>• Certificate of Coverage Cover Page</li> <li>• Certificate of Coverage - <i>Introduction to Your Certificate: Don't Hesitate to Contact Us</i></li> </ul>
Table of Contents	Certificate of Coverage: <i>Table of Contents</i>
Eligibility	Certificate of Coverage: <i>Section 3: When Coverage Begins</i>
How to Access Your Services and Obtain Approval of Benefits	Schedule of Benefits: <i>Accessing Benefits</i>
Benefits/Coverage (What is Covered)	Certificate of Coverage - <i>Section 1: Covered Health Services</i>
Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)	Certificate of Coverage - <i>Section 2: Exclusions and Limitations</i>
Member Payment Responsibility	Schedule of Benefits - <i>Benefits</i>
Claims Procedures (How to File a Claim)	Certificate of Coverage - <i>Section 5: How to File a Claim</i>
General Policy Provisions	Group Policy - <i>Article 6: General Provisions</i>
Termination/Nonrenewal/Continuation	Certificate of Coverage - <i>Section 4: When Coverage Ends</i>
Appeals and Complaints	Certificate of Coverage - <i>Section 6: Questions, Complaints and Appeals</i>
Information on Policy and Rate Changes	Group Policy - <i>Article 3: Premium Rates and Policy Charge</i>
Definitions	Certificate of Coverage - <i>Section 9: Defined Terms</i>

# Home Health Care and Hospice Care Amendment

## UnitedHealthcare Insurance Company

Because this Amendment reflects changes in requirements of insurance law of the State of Colorado, 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 Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and this Amendment below.

1. Home Health Care and Hospice Care in the *Certificate, Section 1: Covered Health Services* are replaced with the following:

### Home Health Care

Home health care services received from a Home Health Agency that are both of the following:

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

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent schedule and when skilled care is required. Home health services are to be covered when services are necessary as alternatives to hospitalization, or in place of hospitalization. Prior hospitalization is not required.

Home health care visits may be included but are not limited to:

- Skilled nursing visits;
- Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the member's illness or Injury;
- Physical, occupational, or speech therapy and language therapy, including audiology services, that is provided on a per visit basis;
- Respiratory and inhalation therapy;
- Nutrition counseling by a nutritionist or dietitian;
- Enteral feedings (tube feedings);
- Medical supplies, Durable Medical Equipment as described under Durable Medical Equipment in the *Certificate* under *Section 1: Covered Health Services*; and
- Infusion therapy medications and supplies and laboratory services as prescribed by a provider to the extent such services would be covered by us had the member remained in the hospital, rehabilitation or Skilled Nursing Facility.
- "Social work practice services" are those services provided by a licensed social worker who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at



the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

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

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

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

## **Hospice Care**

Hospice services are covered for members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six months or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the member's interdisciplinary team, which includes, but is not limited to, the member, the member's Physician, a registered nurse, a social worker and a spiritual caregiver.

Benefits are available when hospice services are received from a hospice agency that is licensed and regulated by the Colorado Department of Public Health and Environment.

Hospice services include:

- Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse and nursing services delegated to other assistants.
- Bereavement support services
- Psychosocial services/counseling services.
- Medical direction.
- Volunteer services.
- Drugs and biologicals.
- Prosthesis and orthopedic appliances.
- Oxygen and respiratory supplies.
- Diagnostic testing.
- Rental or purchase of durable equipment.
- Transportation.
- Nutritional counseling by a nutritionist or dietitian.

- Medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions.
- Physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the member to maintain activities of daily living and basic functional skills.
- Pastoral services.

Covered hospice services are available in the home on a 24-hour basis during periods of crisis, when a member requires continuous care to achieve palliation or management of acute medical symptoms. Home is defined as a place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. Inpatient hospice services are provided in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the member ("respite care"). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

2. Hospice Care in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Hospice Care			
	80%	Yes	Yes

3. The exclusion in the *Certificate* under *Section 2: Exclusions and Limitations*, Nutrition is replaced with the following:

## J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition, except for the first 31 days of life. Benefits for medical foods are described under the *Outpatient Prescription Drug Rider*.
3. Enteral feedings (tube feedings), except when provided as part of a Home Health Care plan of care provided or arranged for by a Home Health Agency, as described under Home Health Care in the *Certificate* under *Section 1: Covered Health Services*.
4. Infant formula and donor breast milk.

5. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
6. The definition of Physician in the *Certificate* under *Section 9: Defined Terms* is replaced with the following:

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

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

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Domestic Partner Amendment

## UnitedHealthcare Insurance Company

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

1. The definitions of Domestic Partner and Domestic Partnership in the *Certificate* under *Section 9: Defined Terms* are replaced with the following:

**Domestic Partner** - a person with whom the Subscriber has established a Domestic Partnership.

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

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

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Health Resources and Services Administration (HRSA) Amendment

## UnitedHealthcare Insurance Company

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

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

### Benefits for Breast Pumps

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. These Benefits are provided as described under *Preventive Care Services* in the *Certificate, Section 1: Covered Health Services* and in the *Schedule of Benefits*.

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

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

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

### Personal Care, Comfort or Convenience

Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

- Air conditioners, air purifiers and filters and dehumidifiers.
- Batteries and battery chargers.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.

- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jeffrey Alter", is positioned above the printed name.

Jeffrey Alter, President

# Questions, Complaints and Appeals Amendment

## UnitedHealthcare Insurance Company

The Policy is modified as described in this Amendment.

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

*The provisions in the Certificate under Section 6: Questions, Complaints and Appeals, are replaced with the following:*

### Section 6: Questions, Complaints and Appeals

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

#### What to Do if You Have a Question

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

#### What to Do if You Have a Complaint

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

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

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

#### How to Appeal a Claim Decision

##### Post-service Claims

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

##### Pre-service Requests for Benefits

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

#### How to Request an Appeal

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

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

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

## Appeals Determinations

### Pre-service Requests for Benefits and Post-service Claim Appeals

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

You will be provided written or electronic notification of the decision on your 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. If you are not satisfied with the first level appeal decision, you may be entitled to request an independent external review as described below, or if the Benefit denial involves an Adverse Determination based on clinical criteria, a Rescission, or a denial of coverage based on an initial eligibility determination, you have the right to request a voluntary second level review. Your voluntary second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. A voluntary second level review will be conducted within 15 days of receipt of the request by a health care professional (reviewer) who was not previously involved in the appeal and who does not have a direct financial interest in the appeal or outcome of the review. You have the right to appear in person or by telephone conference at the voluntary second level review meeting and will be notified in advance of the date of the meeting. Within 7 days of completion of the review meeting, but no later than 15 days of receipt of the voluntary second level review request, you will receive written notification of the decision on your appeal.
- 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. If you are not satisfied with the first level appeal decision, you may be entitled to request an independent external review as described below, or if the Benefit denial involves an Adverse Determination based on clinical criteria, a Rescission, or a denial of coverage based on an initial



eligibility determination, you have the right to request a voluntary second level appeal. Your voluntary second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. A voluntary second level review will be conducted within 30 days of receipt of the request by a health care professional (reviewer) who was not previously involved in the appeal and who does not have a direct financial interest in the appeal or outcome of the review. You have the right to appear in person or by telephone conference at the voluntary second level review meeting and will be notified in advance of the date of the meeting. Within 7 days of completion of the review meeting, but no later than 30 days of receipt of the voluntary second level review request, you will receive written notification of the decision on your appeal.

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

You may have the right to external review through an independent external review entity upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

## **Urgent Appeals that Require Immediate Action**

Your appeal may require 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.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.
- If additional information is needed from you to make a decision, we will notify you of the information required within 24 hours after the urgent request is 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.

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

## **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, 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.

## Independent External Review Program

If, after the completion or exhaustion of the internal appeal process, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations, you may be entitled to request an independent external review of our Adverse Determination. If you are enrolled under a wellness and prevention program that provides incentives or rewards for satisfaction of a standard related to a health risk factor, you may also request an independent external review of our denial of a request for an alternate standard or waiver of a standard otherwise applicable to you under the wellness program.

If one of the above conditions is met, you or your designated representative may request an independent external review of an Adverse Determination based upon any of the following:

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

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

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

You or your designated representative may request an independent external review by sending a written request to the address set out in the Adverse Determination letter:

- Within four months after you receive notification of our final Adverse Determination following the completion or exhaustion of the internal appeal process.
- At the same time as you request an internal urgent appeal if you are requesting a concurrent expedited external review.

An independent external review request must include all of the following:

- A completed external review request form as specified by the *Office of the Commissioner of Insurance*.
- A signed consent form authorizing us to disclose the Covered Person's protected health information, including medical records, that is pertinent to the external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided or considered during the internal appeal process.
- For an expedited external review request, a Physician's certification that the Covered Person has a medical condition for which application of the time period for completion of the internal urgent appeal process or the standard external review process would seriously jeopardize the Covered

Person's life, health, or ability to regain maximum function, or for Covered Persons with a disability, would create an imminent and substantial limitation of their existing ability to live independently.

- For an external review request involving a service that is Experimental or Investigational, certification from the treating Physician that the recommended or requested health care service or treatment will be less effective if not begun immediately, and that:
  - Standard health care services or treatments have not improved the Covered Person's condition or are not medically appropriate for the Covered Person; or
  - There is no standard health care service or treatment available that is covered under the Policy and is more beneficial to the Covered Person than the recommended or requested health care service or treatment, and that the Physician is a board-certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Covered Person's condition.

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

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

**Standard Independent External Review Request:** Your request for an independent external review must be submitted to us in writing within four months of the date you received notice of our Adverse Determination following the completion or exhaustion of the internal appeal process.

1. Within two business days of receipt of your request for an independent external review, we will forward a copy of the request to the *Office of the Commissioner of Insurance* who will select an independent external review entity. If we deny your eligibility for independent external review, we will notify you, your designated representative, and the *Office of the Commissioner of Insurance* in writing with the specific reasons for the denial and information about appealing that determination to the *Office of the Commissioner of Insurance*.
2. If your request is eligible for review, the *Office of the Commissioner of Insurance* will assign an independent external review entity and will notify us of the name and address of the entity within two business days of receipt of the independent external review request.
3. Within one business day of receipt of the *Office of the Commissioner of Insurance's* notice of assignment to an independent external review entity, we will notify you and your designated representative in writing of the name and address of the independent external review entity.
4. Within five business days of the date you receive notice of assignment to an independent external review entity, you or your designated representative may submit any additional information in writing to the independent external review entity that you want the entity to consider in its review.
5. The independent external review entity will conduct its review and will provide written notice of its decision to you and your designated representative, to us, and to the *Office of the Commissioner of Insurance* within 45 calendar days after receipt of the independent external review request.
6. Upon receipt of notice from the independent external review entity that our denial decision is overturned, we will approve coverage of the Covered Health Service that was the subject of the review:
  - Within one business day for concurrent and prospective reviews of pre-service requests for Benefits.
  - Within 5 business days for retrospective reviews of post-service claims.

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

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

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

An expedited independent external review will not be provided for post-service claim denials or for denials of a request for an alternate standard or waiver of a standard applicable to a Covered Person under an applicable wellness and prevention program.

1. Within one business day of receipt of your request for an expedited independent external review, we will forward a copy of the request to the *Office of the Commissioner of Insurance* who will select an independent external review entity. If we deny your eligibility for independent external review, we will notify you, your designated representative, and the *Office of the Commissioner of Insurance* in writing with the specific reasons for the denial and information about appealing that determination to the *Office of the Commissioner of Insurance*.
2. If your request is eligible for review, the *Office of the Commissioner of Insurance* will assign an independent external review entity and will notify us of the name and address of the entity within one business day of receipt of the expedited independent external review request.
3. Within one business day of receipt of the *Office of the Commissioner of Insurance's* notice of assignment to an independent external review entity, we will notify you and your designated representative in writing of the name and address of the independent external review entity.
4. Upon receipt of notice of assignment to an independent external review entity, you or your designated representative may submit any additional information in writing to the independent external review entity that you want the entity to consider in its review.
5. The independent external review entity will conduct its review and will provide notice of its decision to you and your designated representative, to us, and to the *Office of the Commissioner of Insurance* within 72 hours after receipt of the expedited independent external review request. If notice of the independent external review entity's decision is not in writing, the independent external review entity will provide written confirmation of its decision within 48 hours after the date of providing that notice.
6. Immediately upon receipt of notice from the independent external review entity that our denial decision is overturned, we will approve coverage of the Covered Health Service that was the subject of the review and will provide written notice of the approval to you and your designated representative. Coverage will be provided in accordance with the terms and conditions of the Policy.

**Binding Nature of the Independent External Review Decision:** The independent external review decision is binding on both you and us except to the extent that other remedies may be available under federal or state law.

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

You may contact us at the toll-free number on your ID card for more information regarding external review rights.

## Section 9: Defined Terms

*The definition of Rescission is added and the definition of Adverse Determination is replaced with the following in the Certificate under Section 9: Defined Terms:*

**Adverse Determination** - means a determination by us or our designee that a request for a pre-service or post-service Benefit has been reviewed and, based upon the information provided, does not meet the definition of Medically Necessary, or that the Benefit is not appropriate, effective, efficient, is not provided in or at the appropriate health care setting or level of care, or is determined to be an Experimental or Investigational Service, and is therefore denied, reduced or terminated. An Adverse Determination also includes a denial for a Benefit excluded by this Policy for which the Covered Person is able to present evidence from a medical professional that there is reasonable medical basis that the contractual exclusion does not apply to the denied Benefit. An Adverse Determination also includes a rescission or cancellation of coverage not attributed to a failure to pay Premiums that is applied retroactively, as well as a denial of coverage to a Covered Person based on an initial eligibility determination, however, a Physician is not required to evaluate an appeal of these types of Adverse Determinations. For the Independent External Review process, this definition also includes a denial of a request for an alternate standard or waiver of a standard that would otherwise be applicable to a Covered Person under an applicable wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor.

**Rescission** - the cancellation or discontinuance of coverage that has a retrospective effect. This includes a cancellation that treats a Policy as void from the time of enrollment, and a cancellation that voids Benefits paid up to a year before the cancellation takes place. A Rescission of coverage shall be treated as an Adverse Determination. A cancellation or discontinuance of coverage is not a Rescission if the cancellation or discontinuance is exclusively prospective, or the cancellation or discontinuance is retroactive only to the extent attributable to a failure to pay Premiums or contributions toward the cost of coverage in a timely manner.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Clinical Trials, Civil Unions and Patient Protection and Affordable Care Act (PPACA) Related 2014 Provisions Amendment

## UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below. This Amendment is applicable to Policies issued in the state of Colorado.

Because this Amendment reflects changes in requirements of state and 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 Covered Person 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* are replaced as described below:

### Section 1: Covered Health Services

*Clinical Trials in Section 1: Covered Health Services is replaced with the following:*

#### Clinical Trials

Routine patient care costs that a Covered Person receives during a clinical trial will be covered if:

- The Covered Person's provider recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person;
- The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended;
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
- Prior to participation in a clinical trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the clinical trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the Covered Person's health benefit plan, and all out-of-network rates will apply; and
- The Covered Person suffers from a condition that is disabling, progressive, or life-threatening.

Routine patient care costs for qualifying clinical trials include:

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

Routine patient care costs for clinical trials do not include:

- Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
- Costs for the management of research relating to the clinical trial or study; or
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Covered Person's health plan.

"Clinical trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

"Routine patient care cost" means all items and services that are a benefit under a health coverage plan that would be covered if the Covered Person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

## 2. Civil Unions

### Section 3: When Coverage Begins

*The Adding New Dependents and Special Enrollment Period provisions in Section 3: When Coverage Begins are replaced with the following:*

#### **Adding New Dependents**

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

- Birth.

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

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

Newborns are covered for the first 31 days of life. If a specific Premium is required to provide coverage for the newborn, you must submit a completed enrollment form to us prior to the expiration of the 31-day period for coverage to continue beyond the first 31 days of life. If no additional Premium is required to provide coverage for the newborn, you are required to submit a completed enrollment form to us prior to the expiration of the 31-day period.

### **Special Enrollment Period**

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Permanent legal guardianship.
- Court or administrative order.
- Registering a Partner in a Civil Union.
- Registering a Domestic Partner.

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

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



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

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

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

### 3. Defined Terms

## Section 9: Defined Terms

*In Section 9: Defined Terms, the definitions of Civil Union and Partner in a Civil Union are added and the definitions of Dependent and Experimental or Investigational Service(s) are replaced with the following:*

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

- The two parties to the civil union satisfy all of the following criteria:
  - Both parties are adults, regardless of the gender of either party;
  - Neither party is a party to another civil union;
  - Neither party is married to another person;
  - The parties are not related to each other as an ancestor, descendant, brother, sister, uncle, aunt, niece, or nephew, whether the relationship is by the half or the whole blood.

- Neither party is under 18 years of age or 18 years of age or older and under guardianship, unless the party under guardianship has the written consent of his or her guardian.
- The civil union is certified and registered with a county clerk and recorder in the State of Colorado.

**Dependent** - the Subscriber's legal spouse, Common Law Spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Partner in a Civil Union and a Domestic Partner. The term child includes any of the following:

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

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

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

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

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

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

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

**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, except that Benefits are provided for Prescription Drug Products that have been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.
- 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* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, 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 Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

## **2. Additional Patient Protection and Affordable Care Act (PPACA) Related 2014 Provisions**

### **Durable Medical Equipment**

Benefits for Durable Medical Equipment are not subject to the annual dollar limit stated in the *Schedule of Benefits*, however Benefits continue to be subject to the limitation of a single purchase of a type of DME (including repair/replacement) every three years.

### **Prosthetic Devices**

Benefits for prosthetic devices are not subject to the annual dollar limit stated in the *Schedule of Benefits*, however Benefits continue to be subject to the limitation of a single purchase of each type of prosthetic device every three years.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Outpatient Prescription Drug

## UnitedHealthcare Insurance Company

### Schedule of Benefits

#### Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, Depo Provera and other injectable drugs.

#### If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

#### Supply Limits

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

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

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

#### Prior Authorization Requirements

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

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

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

## **Network Pharmacy Prior Authorization**

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

The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

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

The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

## **Step Therapy**

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

## **What You Must Pay**

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

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

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

## Payment Information

Payment Term And Description	Amounts
<p><b>Copayment and Coinsurance</b></p>	
<p><b>Copayment</b></p> <p>Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.</p> <p><b>Coinsurance</b></p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p><b>Copayment and Coinsurance</b></p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p><b>Special Programs:</b> We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p><b>Prescription Drug Products Prescribed by a Specialist Physician:</b> You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p><b>NOTE:</b> The tier status of a Prescription</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment and/or Coinsurance.</li> <li>• The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.</li> </ul> <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment and/or Coinsurance.</li> <li>• The Prescription Drug Charge for that Prescription Drug Product.</li> </ul> <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.</p>

<b>Payment Term And Description</b>	<b>Amounts</b>
<p>Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p>	

## Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p><b>Specialty Prescription Drug Products</b></p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier-1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$15.00 per Prescription Order or Refill.</p> <p>For a Tier-2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$45.00 per Prescription Order or Refill.</p> <p>For a Tier-3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$60.00 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.</p> <p>Benefits for oral chemotherapeutic agents are not subject to payment of the Annual Drug Deductible.</p>
<p><b>Prescription Drugs from a Retail Network Pharmacy</b></p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</li> <li>A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.</li> </ul> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$15.00 per Prescription Order or Refill.</p> <p>For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$45.00 per Prescription Order or Refill.</p> <p>For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of</p>



<b>Description and Supply Limits</b>	<b>Benefit (The Amount We Pay)</b>
consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	<p>\$60.00 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.</p>
<b>Prescription Drug Products from a Mail Order Network Pharmacy</b>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>.</li> </ul> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For up to a 90-day supply, we pay:</p> <p>For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$37.50 per Prescription Order or Refill.</p> <p>For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$112.50 per Prescription Order or Refill.</p> <p>For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$150.00 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.</p>

# Outpatient Prescription Drug Rider

## UnitedHealthcare Insurance Company

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

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

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

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

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Introduction

## Coverage Policies and Guidelines

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

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

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

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

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

## Identification Card (ID Card) - Network Pharmacy

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

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

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

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

## Designated Pharmacies

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

## **Limitation on Selection of Pharmacies**

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

## **Rebates and Other Payments**

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

## **Coupons, Incentives and Other Communications**

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

## **Special Programs**

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

## **Prescription Drug Products Prescribed by a Specialist Physician**

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

# **Outpatient Prescription Drug Rider Table of Contents**

<b>Section 1: Benefits for Prescription Drug Products.....</b>	<b>11</b>
<b>Section 2: Exclusions.....</b>	<b>12</b>
<b>Section 3: Defined Terms.....</b>	<b>14</b>

# Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, Depo Provera and other injectable drugs.

## Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

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

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

## Prescription Drugs from a Retail Network Pharmacy

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

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

## Prescription Drug Products from a Mail Order Network Pharmacy

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

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

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

## Section 2: Exclusions

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

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

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This does not include Prescription Drug Products that have been approved by the *U.S. Food and Drug Administration (FDA)* for use in the treatment of cancer but have not been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
13. Unit dose packaging of Prescription Drug Products.
14. Medications used for cosmetic purposes.

15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility.
18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. 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 for Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders, as specified in *Section 3, Defined Terms* of this Rider.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. 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.
25. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.



## Section 3: Defined Terms

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

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

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

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

**Inherited Enzymatic Disorder** - a disorder caused by single gene defects involved in the metabolism of amino, organic, and fatty acids including, but not limited to the following diagnosed conditions:

- Phenylketonuria in female Covered Persons who are less than 21 years of age.
- Maternal phenylketonuria in female Covered Persons of child bearing age who are less than 35 years old.
- Maple syrup urine disease.
- Tyrosinemia.
- Homocystinuria.
- Urea cycle disorders.
- Hyperlysinemia.
- Glutaric acidemias.
- Methylmalonic ademia.
- Propionic acidemia.

**Medical Foods** - prescription metabolic formulas and their modular counterparts that are:

- Obtained through a pharmacy.
- Specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist.
- Specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a Physician.

The term "Medical Foods" does not include foods for cystic fibrosis patients or lactose or soy intolerant patients.

**Network Pharmacy** - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

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

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

**Prescription Drug Charge** - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

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

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

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

**Preventive Care Medications** - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

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

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

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

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

# Routine Vision Examination Rider

## UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for routine vision examinations, as described below.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms*.

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

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

## Section 1: Benefits for Routine Vision Examinations

Benefits are available for Vision Care Services from a Network Vision Care Provider. To find a Network Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Network Vision Care Providers on the Internet at [www.myuhcvision.com](http://www.myuhcvision.com).

When obtaining these Vision Care Services from a Network Vision Care Provider, you will be required to pay any Copayments at the time of service.

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

### Annual Deductible

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

## Benefit Description

### Benefits

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

### Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Copayments and Coinsurance stated 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.

Vision Care Service	Frequency of Service	Benefit
<i>Routine Vision Examination or Refraction only in lieu of a complete exam.</i>	Once every 24 months.	100% after a Copayment of \$25.

## Section 2: Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Routine Vision Examinations*, 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. Vision Care Services received from a non-Network Vision Care Provider.

## Section 4: Defined Terms

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate*:

**Vision Care Provider** - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

**Vision Care Service(s)** - routine vision examinations listed in this Rider in *Section 1: Benefits for Routine Vision Examinations*.

# 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.

## 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). Under the *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*.

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.

**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 the back of 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 the back of 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 the back of 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 the back of 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 the back of 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](http://www.healthcare.gov).

## **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 July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health 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.

## **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 Annual 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 September 23, 2013*

We<sup>1</sup> 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, we will post the revised notice on your health plan website such as [www.myuhc.com](http://www.myuhc.com) or [www.uhcwest.com](http://www.uhcwest.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.
- **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, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **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 the back of your 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](http://www.myuhc.com) or [www.uhcwest.com](http://www.uhcwest.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 the back of your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center Representative* at 866-633-2446.
- **Submitting a Written Request.** Mail to us 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, 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.

<sup>1</sup>*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 Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, 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.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, 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 New York, Inc.; Physicians Health Choice of Texas, LLC; Preferred Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, 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 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 AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

*Effective September 23, 2013*

We<sup>2</sup> 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

We 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 consumer reports.

### 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 communications on our behalf.

### Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

### Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on the back of your health plan ID card or contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.

<sup>2</sup>For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on page XV of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network,

*Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; ProcessWorks, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; 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.; UnitedHealthOne Agency, 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: June 30, 2013

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:

- Show the categories of health information that are subject to these more restrictive laws; and
- 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

<b>Alcohol &amp; Drug Abuse Information</b>	
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.	
<b>Genetic Information</b>	
We are not allowed to use genetic information for underwriting purposes.	

### Summary of State Laws

<b>General Health Information</b>	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, 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.	MO, NJ, SD
<b>Prescriptions</b>	
We are allowed to disclose prescription-related information only (1) under certain limited	ID, NH, NV



circumstances, and /or (2) to specific recipients.	
<b>Communicable Diseases</b>	
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
<b>Sexually Transmitted Diseases and Reproductive Health</b>	
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
<b>Alcohol and Drug Abuse</b>	
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.	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
<b>Genetic Information</b>	
We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, 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, 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
<b>HIV / AIDS</b>	
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
<b>Mental Health</b>	
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
<b>Child or Adult Abuse</b>	
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, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

**EXHIBIT A-2  
INSURANCE POLICIES**

**UnitedHealth Care Company  
CHOICE POLICY**

**UnitedHealthcare Choice**  
**UnitedHealthcare Insurance Company**

**Certificate of Coverage**

**For**

**the Plan VXP**

**of**

**City and County of Denver**

**Enrolling Group Number: 717340**

**Effective Date: January 1, 2015**

**Offered and Underwritten by**

**UnitedHealthcare Insurance Company**

# **UnitedHealthcare Insurance Company**

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

# Table of Contents

<b>Schedule of Benefits .....</b>	<b>1</b>
Accessing Benefits .....	1
Prior Authorization .....	1
Covered Health Services which Require Prior Authorization .....	2
Care Management.....	2
Special Note Regarding Medicare.....	2
Benefits.....	2
Additional Benefits Required By Colorado Law.....	13
Eligible Expenses .....	15
Provider Network .....	16
Designated Facilities and Other Providers .....	16
Health Services from Non-Network Providers.....	16
Limitations on Selection of Providers .....	17
<b>Certificate of Coverage.....</b>	<b>1</b>
Certificate of Coverage is Part of Policy.....	1
Changes to the Document.....	1
Other Information You Should Have .....	1
<b>Introduction to Your Certificate .....</b>	<b>3</b>
How to Use this Document.....	3
Information about Defined Terms .....	3
Don't Hesitate to Contact Us .....	3
Access Plan.....	3
<b>Your Responsibilities .....</b>	<b>4</b>
Be Enrolled and Pay Required Contributions.....	4
Be Aware this Benefit Plan Does Not Pay for All Health Services .....	4
Decide What Services You Should Receive .....	4
Choose Your Physician .....	4
Obtain Prior Authorization .....	4
Pay Your Share .....	4
Pay the Cost of Excluded Services .....	5
Show Your ID Card.....	5
File Claims with Complete and Accurate Information .....	5
Use Your Prior Health Care Coverage .....	5
<b>Our Responsibilities.....</b>	<b>6</b>
Determine Benefits .....	6
Pay for Our Portion of the Cost of Covered Health Services .....	6
Pay Network Providers .....	6
Pay for Covered Health Services Provided by Non-Network Providers.....	6
Review and Determine Benefits in Accordance with our Reimbursement Policies .....	6
Offer Health Education Services to You.....	7
<b>Certificate of Coverage Table of Contents.....</b>	<b>8</b>
<b>Section 1: Covered Health Services .....</b>	<b>9</b>
Benefits for Covered Health Services .....	9
1. Ambulance Services.....	9
2. Congenital Heart Disease Surgeries .....	10
3. Dental Services - Accident Only .....	10
4. Diabetes Services.....	10
5. Durable Medical Equipment .....	11
6. Emergency Health Services - Outpatient .....	12
7. Hearing Aids for Adults.....	12

8. Hearing Aids for Minor Children .....	12
9. Home Health Care .....	13
10. Hospice Care .....	14
11. Hospital - Inpatient Stay .....	15
12. Lab, X-Ray and Diagnostics - Outpatient .....	15
13. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient .....	15
14. Mental Health Services.....	16
15. Neurobiological Disorders - Autism Spectrum Disorder Services .....	16
16. Ostomy Supplies .....	17
17. Pharmaceutical Products - Outpatient.....	18
18. Physician Fees for Surgical and Medical Services .....	18
19. Physician's Office Services - Sickness and Injury .....	18
20. Pregnancy - Maternity Services .....	18
21. Preventive Care Services .....	19
Additional preventive care services:.....	20
22. Prosthetic Devices .....	20
23. Reconstructive Procedures .....	21
24. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.....	21
25. Scopic Procedures - Outpatient Diagnostic and Therapeutic .....	22
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services .....	22
27. Substance Use Disorder Services.....	23
28. Surgery - Outpatient .....	24
29. Therapeutic Treatments - Outpatient .....	24
30. Transplantation Services .....	25
31. Urgent Care Center Services .....	25
32. Vision Examinations .....	25
Additional Benefits Required By Colorado Law.....	25
33. Autism Spectrum Disorders.....	25
34. Cleft Lip and Cleft Palate Treatment .....	26
35. Clinical Trials and Studies .....	26
36. Colorectal Cancer Screening .....	27
37. Hospitalization and General Anesthesia for Dental Procedures for Children .....	28
38. Phenylketonuria (PKU) Testing and Treatment .....	28
39. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities) .....	29
40. Telemedicine Services .....	29
<b>Section 2: Exclusions and Limitations.....</b>	<b>30</b>
How We Use Headings in this Section.....	30
We do not Pay Benefits for Exclusions .....	30
Benefit Limitations .....	30
A. Alternative Treatments .....	30
B. Dental.....	30
C. Devices, Appliances and Prosthetics.....	31
D. Drugs.....	32
E. Experimental or Investigational or Unproven Services .....	32
F. Foot Care .....	33
G. Medical Supplies.....	33
H. Mental Health.....	33
I. Neurobiological Disorders - Autism Spectrum Disorders .....	34
J. Nutrition.....	35
K. Personal Care, Comfort or Convenience .....	35
L. Physical Appearance.....	36
M. Procedures and Treatments .....	37
N. Providers .....	38
O. Reproduction .....	38

P. Services Provided under another Plan .....	38
Q. Substance Use Disorders .....	39
R. Transplants .....	39
S. Travel .....	39
T. Types of Care .....	40
U. Vision and Hearing .....	40
V. All Other Exclusions .....	40
<b>Section 3: When Coverage Begins .....</b>	<b>43</b>
How to Enroll .....	43
If You Are Hospitalized When Your Coverage Begins .....	43
Who is Eligible for Coverage .....	43
Eligible Person .....	43
Dependent .....	43
When to Enroll and When Coverage Begins .....	43
Initial Enrollment Period .....	44
Open Enrollment Period .....	44
Dependent Child Special Open Enrollment Period .....	44
New Eligible Persons .....	44
Adding New Dependents .....	44
Special Enrollment Period .....	45
<b>Section 4: When Coverage Ends .....</b>	<b>47</b>
General Information about When Coverage Ends .....	47
Events Ending Your Coverage .....	47
Other Events Ending Your Coverage .....	48
Coverage for a Disabled Dependent Child .....	48
Extended Coverage If You Are Hospitalized .....	48
Continuation of Coverage and Conversion .....	48
Qualifying Events for Continuation Coverage under State Law .....	49
Notification Requirements and Election Period for Continuation Coverage under State Law .....	49
Terminating Events for Continuation Coverage under State Law .....	50
Conversion .....	50
<b>Section 5: How to File a Claim .....</b>	<b>51</b>
If You Receive Covered Health Services from a Network Provider .....	51
If You Receive Covered Health Services from a Non-Network Provider .....	51
Required Information .....	51
Payment of Benefits .....	51
<b>Section 6: Questions, Complaints and Appeals .....</b>	<b>53</b>
What to Do if You Have a Question .....	53
What to Do if You Have a Complaint .....	53
How to Appeal a Claim Decision .....	53
Post-service Claims .....	53
Pre-service Requests for Benefits .....	53
How to Request an Appeal .....	53
Appeal Process .....	54
Appeals Determinations .....	54
Pre-service Requests for Benefits and Post-service Claim Appeals .....	54
Urgent Appeals that Require Immediate Action .....	54
Independent External Review Program .....	55
<b>Section 7: Coordination of Benefits .....</b>	<b>56</b>
Benefits When You Have Coverage under More than One Plan .....	56
When Coordination of Benefits Applies .....	56
Definitions .....	56
Order of Benefit Determination Rules .....	57
Effect on the Benefits of This Plan .....	59



Right to Receive and Release Needed Information .....	60
Payments Made.....	60
Right of Recovery .....	60
When Medicare is Secondary.....	60
<b>Section 8: General Legal Provisions .....</b>	<b>61</b>
Your Relationship with Us .....	61
Our Relationship with Providers and Enrolling Groups .....	61
Your Relationship with Providers and Enrolling Groups .....	62
Notice.....	62
Notice of Continuation .....	62
Notice of Conversion .....	62
Statements by Enrolling Group or Subscriber .....	63
Incentives to Providers .....	63
Incentives to You .....	63
Rebates and Other Payments .....	63
Interpretation of Benefits .....	63
Administrative Services .....	64
Amendments to the Policy.....	64
Information and Records .....	64
Examination of Covered Persons .....	65
Workers' Compensation not Affected.....	65
Subrogation and Reimbursement.....	65
Refund of Overpayments.....	67
Limitation of Action .....	67
Entire Policy.....	67
<b>Section 9: Defined Terms.....</b>	<b>68</b>

## **Amendments, Riders and Notices (As Applicable)**

### **Standard Section Names**

**Home Health Care and Hospice Care Amendment**

**Domestic Partner Amendment**

**Health Resources and Services Administration (HRSA) Amendment**

**Questions, Complaints and Appeals Amendment**

**Clinical Trials, Civil Unions and Patient Protection and Affordable Care Act (PPACA) Related 2014 Provisions Amendment**

**Outpatient Prescription Drug Rider**

**Routine Vision Examination Rider**

**Important Notices under the Patient Protection and Affordable Care Act (PPACA)**

**Changes in Federal Law that Impact Benefits**

**Women's Health and Cancer Rights Act of 1998**

**Statement of Rights under the Newborns' and Mothers' Health Protection Act**

**Claims and Appeal Notice**

**Health Plan Notices of Privacy Practices**

**Financial Information Privacy Notice  
Health Plan Notice of Privacy Practices: Federal and State  
Amendments**

# UnitedHealthcare Choice

## UnitedHealthcare Insurance Company

### Schedule of Benefits

#### Accessing Benefits

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this Schedule of Benefits, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

**Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Covered Health Services received at an Urgent Care Center outside your geographic area and Emergency Health Services.

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

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

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

#### Prior Authorization

We recommend that you notify us before you receive certain Covered Health Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which we recommend that you notify us to ensure that Benefits are available. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

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

**Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

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

## Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air and ground.
- Autism Spectrum Disorders.
- Clinical Trials and Studies.
- Cleft Lip and Cleft Palate Treatment.
- Congenital heart disease surgery.
- Hospitalization and General Anesthesia for Dental Procedures for Children.
- Phenylketonuria (PKU) Testing and Treatment.
- Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities).
- Transplants.

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

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

## Care Management

When we are notified as recommended, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

## Special Note Regarding Medicare

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

## Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

Mammography benefits are provided on a calendar year basis.

Payment Term And Description	Amounts
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Payment Term And Description	Amounts
<b>Annual Deductible</b>	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	No Annual Deductible.
<b>Out-of-Pocket Maximum</b>	
<p>The maximum you pay per year for Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> <li>• Any charges for non-Covered Health Services.</li> <li>• Charges that exceed Eligible Expenses.</li> <li>• Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum.</li> </ul>	\$3,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family.
<b>Copayment</b>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment.</li> <li>• The Eligible Expense.</li> </ul> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
<b>Coinsurance</b>	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p>	

<b>Payment Term And Description</b>	<b>Amounts</b>
Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.	

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>1. Ambulance Services</b>			
<b>Prior Authorization Recommendation</b>  In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you should obtain authorization as soon as possible prior to transport so that we can determine whether the service meets the definition of a Covered Health Service.			
<b>Emergency Ambulance</b>  <b>Non-Emergency Ambulance</b> Ground or air ambulance, as we determine appropriate.	<i>Ground Ambulance:</i> 100%  <i>Air Ambulance:</i> 100%  <i>Ground Ambulance:</i> 100%  <i>Air Ambulance:</i> 100%	No  No  No  No	No  No  No  No
<b>2. Congenital Heart Disease Surgeries</b>			
Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .	100% after you pay a Copayment of \$500 per day to a maximum Copayment of \$2,500 per Inpatient Stay	Yes	No
<b>3. Dental Services - Accident Only</b>			
	100%	No	No
<b>4. Diabetes Services</b>			
<b>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</b>  <b>Diabetes Self-Management Items</b>	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .  Depending upon where the Covered Health Service is		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i> .	provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
<b>5. Durable Medical Equipment</b>			
Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums.  You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	100%	No	No
<b>6. Emergency Health Services - Outpatient</b>			
<b>Note:</b> If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 48 hours or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided.	100% after you pay a Copayment of \$300 per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	No	No
<b>7. Hearing Aids for Adults</b>			
Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	100%	No	No
<b>8. Hearing Aids for Minor Children</b>			
Depending upon where the Covered Health Service is			



Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>9. Home Health Care</b>			
<p>Limited to 60 visits per year. One visit equals up to four hours of skilled care services.</p> <p>This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p>	100%	No	No
<b>10. Hospice Care</b>			
Bereavement support services are limited to \$1,150 during the 12-month period following the Covered Person's death.	100%	No	No
<b>11. Hospital - Inpatient Stay</b>			
	100% after you pay a Copayment of \$500 per day to a maximum Copayment of \$2,500 per Inpatient Stay	Yes	No
<b>12. Lab, X-Ray and Diagnostics - Outpatient</b>			
<p><b>Lab Testing - Outpatient</b></p> <p><b>X-Ray and Other Diagnostic Testing - Outpatient</b></p>	<p><b>Network</b></p> <p>100%</p> <p><b>Network</b></p> <p>100%</p>	<p>No</p> <p>No</p>	<p>No</p> <p>No</p>
<b>13. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>			
	<p><b>Network</b></p> <p>100% after you pay a Copayment of \$100 per service</p>	Yes	No
<b>14. Mental Health Services</b>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p><i>Inpatient</i></p> <p><b>Non-Biologically Based Mental Illness or Mental Disorders</b></p> <p>100% after you pay a Copayment of \$500 per day to a maximum Copayment of \$2,500 per Inpatient Stay</p> <p><b>Biologically Based Mental Illness or Mental Disorders</b></p> <p>100% after you pay a Copayment of \$500 per inpatient day to a maximum Copayment of \$2,500 per Inpatient Stay</p> <p><i>Outpatient</i></p> <p><b>Non-Biologically Based Mental Illness or Mental Disorders</b></p> <p>100% after you pay a Copayment of \$35 per visit</p> <p><b>Biologically Based Mental Illness or Mental Disorders</b></p> <p>100% after you pay a Copayment of \$35 per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p>
<p><b>15. Neurobiological Disorders - Autism Spectrum Disorder Services</b></p>			
	<p><i>Inpatient</i></p> <p>100% after you pay a Copayment of \$500 per day to a maximum</p>	<p>Yes</p>	<p>No</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$2,500 per Inpatient Stay  <i>Outpatient</i>  100% after you pay a Copayment of \$35 per visit	Yes	No
<b>16. Ostomy Supplies</b>			
Limited to \$2,500 per year.	100%	No	No
<b>17. Pharmaceutical Products - Outpatient</b>			
	100%	No	No
<b>18. Physician Fees for Surgical and Medical Services</b>			
	100%	No	No
<b>19. Physician's Office Services - Sickness and Injury</b>			
<p>In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> <li>• Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i></li> <li>• Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i></li> <li>• Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i></li> <li>• Outpatient surgery procedures described under <i>Surgery -</i></li> </ul>	100% after you pay a Copayment of \$35 per visit for a Primary Physician office visit or \$60 per visit for a Specialist Physician office visit	Yes	No

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Outpatient.</i></p> <ul style="list-style-type: none"> <li>Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i></li> </ul>			
<b>20. Pregnancy - Maternity Services</b>			
<p align="center"><b>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</b></p>			
	<p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.</p>		
<b>21. Preventive Care Services</b>			
<b>Physician office services</b>	100%	No	No
<b>Lab, X-ray or other preventive tests</b>	100%	No	No
<b>Additional Preventive Care Services</b>	100%	No	No
<b>22. Prosthetic Devices</b>			
<p>Limited to \$2,500 per year. Benefits are limited to a single purchase of each type of prosthetic device every three years.</p> <p>Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998</i> and for prosthetic arms, legs, feet and hands.</p>	100%	No	No
<b>23. Reconstructive Procedures</b>			
	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<b>24. Rehabilitation Services - Outpatient Therapy and</b>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>Manipulative Treatment</b>			
Limited per year as follows: <ul style="list-style-type: none"> <li>• 20 visits of physical therapy.</li> <li>• 20 visits of occupational therapy.</li> <li>• 20 Manipulative Treatments.</li> <li>• 20 visits of speech therapy.</li> <li>• 20 visits of pulmonary rehabilitation therapy.</li> <li>• 36 visits of cardiac rehabilitation therapy.</li> <li>• 30 visits of post-cochlear implant aural therapy.</li> <li>• 20 visits of cognitive rehabilitation therapy.</li> </ul>	100% after you pay a Copayment of \$60 per visit	Yes	No
<b>25. Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>			
	<i>Network</i> 100%	No	No
<b>26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>			
Limited to 60 days per year.	100% after you pay a Copayment of \$500 per day to a maximum Copayment of \$2,500 per Inpatient Stay	Yes	No
<b>27. Substance Use Disorder Services</b>			
	<i>Inpatient</i> 100% after you pay a Copayment of \$500 per day to a maximum Copayment of \$2,500	Yes	No

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	per Inpatient Stay  <i>Outpatient</i>  100% after you pay a Copayment of \$35 per visit	Yes	No
<b>28. Surgery - Outpatient</b>			
	<b>Network</b>  100% after you pay a Copayment of \$350 per date of service	Yes	No
<b>29. Therapeutic Treatments - Outpatient</b>			
	<b>Network</b>  100%	No	No
<b>30. Transplantation Services</b>			
<b>Prior Authorization Recommendation</b>  You should obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>31. Urgent Care Center Services</b>			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:  <ul style="list-style-type: none"> <li>• Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.</li> <li>• Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products -</i></li> </ul>	100% after you pay a Copayment of \$100 per visit	Yes	No

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Outpatient.</i></p> <ul style="list-style-type: none"> <li>Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i></li> <li>Outpatient surgery procedures described under <i>Surgery - Outpatient.</i></li> <li>Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i></li> </ul>			
<b>32. Vision Examinations</b>			
Limited to 1 exam every 2 years.	100% after you pay a Copayment of \$30 per visit	Yes	No
<b>Additional Benefits Required By Colorado Law</b>			
<b>33. Autism Spectrum Disorders</b>			
<p align="center"><b>Prior Authorization Recommendation</b></p> <p>Depending upon where the Covered Health Service is provided, prior authorization recommendations will be the same as those stated under the applicable Covered Health Service category in the Schedule of Benefits.</p>			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>		
<b>34. Cleft Lip and Cleft Palate Treatment</b>			
<p align="center"><b>Prior Authorization Recommendation</b></p> <p>You should obtain prior authorization as soon as the possibility of participation in a clinical trial arises so that we can determine whether the service meets the definition of a Covered Health Service.</p>			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>35. Clinical Trials and Studies</b>			
<p style="text-align: center;"><b>Prior Authorization Recommendation</b></p> <p>You should obtain prior authorization as soon as the possibility of participation in a clinical trial arises so that we can determine whether the service meets the definition of a Covered Health Service.</p>			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<b>36. Colorectal Cancer Screening</b>			
	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<b>37. Hospitalization and General Anesthesia for Dental Procedures for Children</b>			
<p style="text-align: center;"><b>Prior Authorization Recommendation</b></p> <p>You should obtain prior authorization as soon as reasonably possible of the need for treatment so that we can determine whether the service meets the definition of a Covered Health Service.</p>			
	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<b>38. Phenylketonuria (PKU) Testing and Treatment</b>			
<p style="text-align: center;"><b>Prior Authorization Recommendation</b></p> <p>Depending upon where the Covered Health Service is provided, prior authorization recommendations will be the same as those stated under each Covered Health Service category in this Schedule of</p>			



Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Benefits.			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>39. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)</b>			
<b>Prior Authorization Recommendation</b>			
You should obtain prior authorization five business days before receiving or as soon as reasonably possible so that we can determine whether the service meets the definition of a Covered Health Service.			
Limited per year as follows:  Care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered 20 visits each for physical, occupational and speech therapy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	100% after you pay a Copayment of \$60 per visit	Yes	No
<b>40. Telemedicine</b>			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

## Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. You are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- Health care services provided at a Network Facility, including services provided by a non-Network provider are to be provided to you at no greater cost than if services were obtained by a network provider.

- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

Please refer to [www.myuhc.com](http://www.myuhc.com) or call the telephone number for *Customer Care* listed on your ID card for more information.

## Provider Network

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

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

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

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

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

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

## Designated Facilities and Other Providers

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

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

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

## Health Services from Non-Network Providers

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

Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

## **Limitations on Selection of Providers**

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

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

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

# Certificate of Coverage

## UnitedHealthcare Insurance Company

### Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

You can review the Policy at the office of the Enrolling Group during regular business hours. The *Group Policy* describes the contractual obligations agreed to between us and the Enrolling Group.

### Changes to the Document

Changes to the Policy and this *Certificate* must be in writing. We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages. For details, see *Amendments to the Policy* in *Section 8: General Legal Provisions*.

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

### Other Information You Should Have

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

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

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

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

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an

insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the *Office of the Commissioner of Insurance* within the *Department of Regulatory Agencies*.

# Introduction to Your Certificate

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

## How to Use this Document

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

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

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

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

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

## Information about Defined Terms

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

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

## Don't Hesitate to Contact Us

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

## Access Plan

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

# Your Responsibilities

## Be Enrolled and Pay Required Contributions

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

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

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

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

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

## Decide What Services You Should Receive

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

## Choose Your Physician

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

## Obtain Prior Authorization

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

## Pay Your Share

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

## **Pay the Cost of Excluded Services**

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

## **Show Your ID Card**

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

## **File Claims with Complete and Accurate Information**

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

## **Use Your Prior Health Care Coverage**

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



# Our Responsibilities

## Determine Benefits

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

We have the discretion to do the following:

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

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

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

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

## Pay Network Providers

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

## Pay for Covered Health Services Provided by Non-Network Providers

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

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

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. Health care services provided at a Network facility, including services provided by a Non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

## **Offer Health Education Services to You**

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

# Certificate of Coverage Table of Contents

<b>Section 1: Covered Health Services .....</b>	<b>9</b>
<b>Section 2: Exclusions and Limitations.....</b>	<b>30</b>
<b>Section 3: When Coverage Begins .....</b>	<b>43</b>
<b>Section 4: When Coverage Ends .....</b>	<b>47</b>
<b>Section 5: How to File a Claim .....</b>	<b>51</b>
<b>Section 6: Questions, Complaints and Appeals.....</b>	<b>53</b>
<b>Section 7: Coordination of Benefits .....</b>	<b>56</b>
<b>Section 8: General Legal Provisions .....</b>	<b>61</b>
<b>Section 9: Defined Terms .....</b>	<b>68</b>

# Section 1: Covered Health Services

## Benefits for Covered Health Services

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

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

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

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

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

### 1. Ambulance Services

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

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

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

## **2. Congenital Heart Disease Surgeries**

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

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

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

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

## **3. Dental Services - Accident Only**

Dental services when all of the following are true:

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

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

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

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

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

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

## **4. Diabetes Services**

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

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

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

### **Diabetic Self-Management Items**

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

## **5. Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

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

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.

- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

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

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

Benefits are available for repairs and replacement, except that:

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

## **6. Emergency Health Services - Outpatient**

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

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

Health care services provided at a Network facility, including services provided by a non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider.

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

## **7. Hearing Aids for Adults**

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) for adults age 18 and older. Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

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

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

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

## **8. Hearing Aids for Minor Children**

Hearing aids for a minor child, which is a person under the age of 18 years, who has a hearing loss that has been verified by a licensed Physician and by an audiologist are covered. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following:

- Initial hearing aids and replacement hearing aids not more frequently than every five years;
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.
- "Hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" shall include any parts or ear molds.

## 9. Home Health Care

Home health care services received from a Home Health Agency that are both of the following:

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

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required. Home health services are to be covered when services are necessary as alternatives to hospitalization, or in place of hospitalization. Prior hospitalization is not required.

Home health care visits may be included but are not limited to:

- Skilled nursing visits;
- Home health aide services visits that provide supportive care in the home which are reasonable and necessary to the member's illness or Injury;
- Physical, occupational, or speech therapy and audiology services that is provided on a per visit basis;
- Respiratory and inhalation therapy;
- Nutrition counseling by a nutritionist or dietitian;
- Medical supplies, Durable Medical Equipment; and
- Infusion therapy medications and supplies and laboratory services as prescribed by a provider to the extent such services would be covered by us had the member remained in the hospital, rehabilitation or Skilled Nursing Facility.

"Medical social services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a Physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

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

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.



- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

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

## 10. Hospice Care

Hospice services are covered for members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six months or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the member's interdisciplinary team, which includes, but is not limited to, the member, the member's Physician, a registered nurse, a social worker and a spiritual caregiver.

Benefits are available when hospice services are received from a hospice agency that is licensed and regulated by the *Colorado Department of Public Health and Environment*.

Hospice services include:

- Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse and nursing services delegated to other assistants.
- Bereavement services (limited to a maximum of \$1,150 during the 12-month period following death).
- Social services/counseling services.
- Medical direction.
- Volunteer services.
- Drugs and biologicals.
- Prosthesis and orthopedic appliances.
- Oxygen and respiratory supplies.
- Diagnostic testing.
- Rental or purchase of durable equipment.
- Transportation.
- Physician services.
- Nutritional counseling by a nutritionist or dietitian.
- Medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions.
- Physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the member to maintain activities of daily living and basic functional skills.

Covered hospice services are available in the home on a 24-hour basis during periods of crisis, when a member requires continuous care to achieve palliation or management of acute medical symptoms.

Home is defined as a place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. Inpatient hospice services are provided in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the member ("respite care"). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or Injuries.

## **11. Hospital - Inpatient Stay**

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

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

## **12. Lab, X-Ray and Diagnostics - Outpatient**

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

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

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

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

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

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

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

Benefits under this section include:

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

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

## **14. Mental Health Services**

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility, including services to treat Biologically Based Mental Illness and Mental Disorders.

Benefits include treatment of Mental Illness whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

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

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

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

### **Special Mental Health Programs and Services**

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

## **15. Neurobiological Disorders - Autism Spectrum Disorder Services**

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

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders for which benefits are not subject to any age limit. Medical treatment of Autism Spectrum Disorders for Enrolled Dependent children from birth through 18 years of age is a Covered Health Service for which Benefits are available under *Additional Benefits Required by Colorado Law - Autism Spectrum Disorders* below. Medical treatment of Autism Spectrum Disorders for all other Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this *Certificate*.

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Prescription drug products when prescribed by a licensed Physician.
- Individual, family, therapeutic group, and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

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

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

## **16. Ostomy Supplies**

Benefits for ostomy supplies are limited to the following:

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

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

## **17. Pharmaceutical Products - Outpatient**

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

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

## **18. Physician Fees for Surgical and Medical Services**

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

## **19. Physician's Office Services - Sickness and Injury**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

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

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

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

Benefits under this section include allergy injections.

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

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

## **20. Pregnancy - Maternity Services**

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

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include genetic counseling and testing when there is a reasonable probability that, because of family history, parental age, or exposure to an agent which might cause birth defects or cancer in the fetus, the results will affect medical decisions involving the existing Pregnancy. Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

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

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

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

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

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

## **21. Preventive Care Services**

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

### **Physician office services:**

- Routine physical examinations.
- Well-baby and well-child care.
- Immunizations. Immunization deficient children are not bound by "recommended ages".
- Cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the *United States Department of Health and Human Services*.
- Hearing screening.
- Child Health Supervision Services.

### **Lab, X-ray or other preventive tests:**

- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening, including:
  - One screening per year for Covered Persons age 50 and over.
  - One screening per year for Covered Persons age 40 and over who are in high risk categories, as determined by a Physician.

- Bone mineral density tests.

### **Additional preventive care services:**

Covered preventive care services, in accordance with the A or B recommendations of the Task Force, include the following services:

- Alcohol misuse screening and behavioral counseling interventions for adults by your Primary Physician.
- Cervical cancer screening.
- Breast cancer screening with mammography per calendar year or contract year. Please refer to your *Schedule of Benefits* to determine whether your Benefits are provided on a calendar year or contract year basis.
- Cholesterol screening for lipid disorders.
- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps.
- Colorectal cancer screening coverage for members in accordance with A or B recommendations of the Task Force.
- Colorectal cancer screening coverage for members who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a participating provider.
- Childhood immunizations pursuant to the schedule established by the ACIP.
- Influenza vaccinations pursuant to the schedule established by the ACIP.
- Pneumococcal vaccinations pursuant to the schedule established by the ACIP.
- Tobacco use screening of adults and tobacco cessation interventions by your Primary Physician.

"ACIP" means the advisory committee on immunization practices to the *Centers for Disease Control and Prevention* in the *Federal Department of Health and Human Services*, or any successor entity.

"A recommendation" means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

"B recommendation" means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

"Task force" means the *U.S. Preventive Services Task Force*, or any successor organization, sponsored by the *Agency for Healthcare Research and Quality*, the *Health Services Research Arm of the Federal Department of Health and Human Services*.

## **22. Prosthetic Devices**

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

- Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria and are not subject to the Durable Medical Equipment Benefit limits. Bionic,

myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria. Benefits are available for repairs and replacement, except that there are no Benefits for:

- Repairs due to misuse, malicious damage or gross neglect, and
  - Replacement due to misuse, malicious damage or gross neglect or for lost prosthetic devices.
- Artificial arms, legs, feet and hands.
  - Artificial face, eyes, ears and nose.
  - Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

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

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

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

Benefits are available for repairs and replacement, except that:

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

### **23. Reconstructive Procedures**

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

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

### **24. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.



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

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

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

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

## **25. Scopic Procedures - Outpatient Diagnostic and Therapeutic**

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

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

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

Benefits under this section include:

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

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

## **26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

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

- Supplies and non-Physician services received during the Inpatient Stay.

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

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

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

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

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

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

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

## **27. Substance Use Disorder Services**

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

Benefits include treatment of substance use whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice system.

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

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

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

### **Special Substance Use Disorder Programs and Services**

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

## **28. Surgery - Outpatient**

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

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

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

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Health care services provided at a Network facility, including services provided by a non-Network provider are to be provided to you at no greater cost than if the services were obtained by a Network provider.

## **29. Therapeutic Treatments - Outpatient**

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

### **30. Transplantation Services**

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

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

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

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

### **31. Urgent Care Center Services**

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

### **32. Vision Examinations**

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

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

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

## **Additional Benefits Required By Colorado Law**

### **33. Autism Spectrum Disorders**

Benefits are provided for Covered Health Services for an Enrolled Dependent who is under the age of 19 and who has been diagnosed with Autism Spectrum Disorders. Benefits are provided for the services listed below. Benefits for psychiatric treatment for Autism Spectrum Disorders (including Applied Behavioral Analysis) are described under *Neurobiological Disorders - Autism Spectrum Disorder Services*.

- Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorders; and
- Treatment of Autism Spectrum Disorders through speech therapy, occupational therapy, and physical therapy. The visit limits described under *Rehabilitative Services - Outpatient Therapy and Manipulative Treatment* in this *Certificate* for speech therapy, occupational therapy, and physical therapy do not apply to *Autism Spectrum Disorders*.

Benefits are limited to treatment that is prescribed by the Covered Person's treating Physician in accordance with a treatment plan. The treatment plan must include, but is not limited to, the following:

- The diagnosis.
- The proposed treatment by types.
- The frequency and duration of treatment.
- The anticipated outcomes stated as goals.
- The frequency with which the treatment plan will be updated.
- The signature of the treating Physician.
- Evaluation and assessment services.

### **34. Cleft Lip and Cleft Palate Treatment**

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

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.
- Prosthodontic services.

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

### **35. Clinical Trials and Studies**

Routine patient care costs that a member receives during a Clinical Trial will be covered if:

- The member's provider recommends participation in the Clinical Trial after determining that participation in the Clinical Trial has the potential to provide a therapeutic health benefit to the member;
- The Clinical Trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding Clinical Trials, as amended;
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;

- Prior to participation in a Clinical Trial or study, the member has signed a statement of consent indicating that the member has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the Clinical Trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the member's health benefit plan, and all out-of-network rates will apply; and
- The member suffers from a condition that is disabling, progressive, or life-threatening.

Coverage does not include:

- Any portion of the Clinical Trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- Extraneous expenses related to participation in the Clinical Trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
- Costs for the management of research relating to the Clinical Trial or study; or
- Health care services that, except for the fact that they are being provided in a Clinical Trial, are otherwise specifically excluded from coverage under the member's health plan.

"Clinical Trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

"Routine Patient Care Cost" means all items and services that are a benefit under a health coverage plan that would be covered if the member were not involved in either the experimental or the control arms of a Clinical Trial; except the investigational item or service itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in Clinical Trials that include items or services that are typically provided absent a Clinical Trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

### **36. Colorectal Cancer Screening**

Coverage for the early detection of colorectal cancer and adenomatous polyps for those members who are asymptomatic, average risk adults who are 50 years of age or older and members who are at high risk for colorectal cancer, including Covered Persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a Network provider.

The following tests are covered as determined by a Network provider that detect adenomatous polyps or colorectal cancer: Modalities that are currently included in an "A recommendation" or a "B recommendation" by the Task Force.

- "A recommendation" means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the Task Force:
  - Found good evidence that the preventive health care service improves important health outcomes; and
  - Concluded that the benefits of the preventive health care service substantially outweigh its harms.
- "B recommendation" means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the Task Force:
  - Found at least fair evidence that the preventive health care service improves important health outcomes; and
  - Concluded that the benefits of the preventive health care service outweigh its harms.

"Task force" means the *U.S. Preventive Services Task Force*, or any successor organization, sponsored by the *Agency for Healthcare Research and Quality*, the *Health Services Research Arm of the Federal Department of Health and Human Services*.

If additional therapeutic or surgical services are required during the screening as a result of screening findings, the Outpatient Surgery Copayment will apply.

### **37. Hospitalization and General Anesthesia for Dental Procedures for Children**

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

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

### **38. Phenylketonuria (PKU) Testing and Treatment**

Testing for phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. Medical foods, for the purpose of this Benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical foods are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects.

Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not limited to, the following diagnosed conditions: phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent Medically Necessary, medical foods for home use for which a participating Physician has issued a written, oral or electronic prescription. Benefits for medical foods are described under the *Outpatient Prescription Drug Rider*.

The maximum age to receive this Benefit is 21, except that the maximum age for women who are of child-bearing age is 35.

### **39. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)**

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

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

### **40. Telemedicine Services**

Covered Health Services received through telemedicine if:

- The Colorado county in which you reside has the technology necessary for the provision of telemedicine; and
- In-person care from a Network provider is not available to you within your geographic area.

Face-to-face contact is not required between you and your provider for services appropriately provided through telemedicine, subject to all terms and conditions of the Policy.

For purposes of this Benefit, "telemedicine" is the delivery of medical services and diagnosis, consultation or treatment using interactive audio, interactive video or interactive data communication. Consultation provided by a provider using telephone or facsimile machine is not telemedicine.



## Section 2: Exclusions and Limitations

### How We Use Headings in this Section

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

### We do not Pay Benefits for Exclusions

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

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

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

### Benefit Limitations

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

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

### A. Alternative Treatments

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

### B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as described under *Hospitalization and General*

*Anesthesia for Dental Procedures for Children and Cleft Lip and Cleft Palate Treatment in Section 1: Covered Health Services.*

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

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.
- As described under *Hospitalization and General Anesthesia for Dental Procedures for Children* in *Section 1: Covered Health Services*.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

### **C. Devices, Appliances and Prosthetics**

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
  - Blood pressure cuff/monitor.
  - Enuresis alarm.
  - Non-wearable external defibrillator.

- Trusses.
  - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech.
  6. Oral appliances for snoring.
  7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
  8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

#### **D. Drugs**

1. Prescription drug products for outpatient use that are filled by a prescription order or refill, except as described under *Reproductive Services Products* and *Tobacco Cessation Products* described in *Section 1: Covered Health Services*.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

#### **E. Experimental or Investigational or Unproven Services**

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

- The drug has been approved by the *U.S. Food and Drug Administration (FDA)* as an "investigational new drug for treatment use."
- If it is a drug classified by the *National Cancer Institute* as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in *FDA* regulations.
- The drug has been approved by the *FDA* for use in the treatment of cancer but has not been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.

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

## **F. Foot Care**

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

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

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

## **G. Medical Supplies**

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Compression stockings.
  - Ace bandages.
  - Gauze and dressings.
  - Urinary catheters.

This exclusion does not apply to:

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

## **H. Mental Health**

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

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

## **I. Neurobiological Disorders - Autism Spectrum Disorders**

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

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
3. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.
6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
7. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder for an Enrolled Dependent 19 years of age or older.
8. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
  - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
  - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
  - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

## **J. Nutrition**

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition, except for the first 31 days of life. Benefits for medical foods are described under the *Outpatient Prescription Drug Rider*.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

## **K. Personal Care, Comfort or Convenience**

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters and dehumidifiers.

- Batteries and battery chargers.
- Breast pumps.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

## **L. Physical Appearance**

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.

- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
  3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
  4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
  5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
  6. Wigs regardless of the reason for the hair loss.

## **M. Procedures and Treatments**

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except:
  - As described under *Rehabilitation Services - Outpatient Therapy* in *Section 1: Covered Health Services*; or
  - As required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.
  - Therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity; or
  - As described under *Cleft Lip and Cleft Palate Treatment* in *Section 1: Covered Health Services*.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.



11. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
12. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
13. Surgical and non-surgical treatment of obesity.
14. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures in Section 1: Covered Health Services*.
16. In vitro fertilization regardless of the reason for treatment.

## **N. Providers**

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

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

This exclusion does not apply to mammography.

## **O. Reproduction**

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

## **P. Services Provided under another Plan**

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

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

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

## **Q. Substance Use Disorders**

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

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

## **R. Transplants**

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

## **S. Travel**

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

## T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## U. Vision and Hearing

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

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

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

This exclusion does not apply to hearing aids for minor children as described under *Hearing Aids for Minor Children*.

## V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
  - Medically Necessary.

- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
  - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
    - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption. This exclusion does not apply to treatment for Injuries resulting from a Covered Person's casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding.
    - Related to judicial or administrative proceedings or orders except as described under *Substance Use Disorder Services*.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials and Studies* in *Section 1: Covered Health Services*.
    - Required to obtain or maintain a license of any type.
  3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
  4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
  5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
  6. In the event a non-Network 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.
  7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
  8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
  9. Autopsy.
  10. Foreign language and sign language services.
  11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

12. Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. For purposes of this exclusion, "pain management" means a pain state in which the cause of the pain cannot be removed and which, in the generally accepted course of medical practice, no relief or cure of the cause of pain is possible,

or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area.

13. Consultation by a provider by telephone or facsimile.

## Section 3: When Coverage Begins

### How to Enroll

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

### If You Are Hospitalized When Your Coverage Begins

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

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

### Who is Eligible for Coverage

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

#### Eligible Person

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

Eligible Persons must reside within the United States.

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

#### Dependent

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

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

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

### When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents. When you enroll you must submit all enrollment forms and any required payment to the Enrolling Group. The Enrolling Group is responsible for forwarding all enrollment information to us and for making required payment to us.

## **Initial Enrollment Period**

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

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

## **Open Enrollment Period**

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

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

## **Dependent Child Special Open Enrollment Period**

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

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

## **New Eligible Persons**

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

## **Adding New Dependents**

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

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

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

Newborns are covered for the first 31 days of life. If a specific Premium is required to provide coverage for the newborn, you must submit a completed enrollment form to us prior to the expiration of the 31-day period for coverage to continue beyond the first 31 days of life. If no additional Premium is required to

provide coverage for the newborn, you are required to submit a completed enrollment form to us prior to the expiration of the 31-day period.

## **Special Enrollment Period**

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

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

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

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

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

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



- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

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

## Section 4: When Coverage Ends

### General Information about When Coverage Ends

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

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

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

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

### Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended. See the *Notice of Conversion* provision in *Section 8: General Legal Provisions*.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." The Subscriber or the Enrolling Group is responsible for providing us written notice to end your coverage.

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

## Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff.

## Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if the Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

## Extended Coverage If You Are Hospitalized

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage would otherwise terminate, coverage will be extended until the date your Inpatient Stay ends. This extension of coverage does not apply if termination occurs due to nonpayment of Premium or fraud. This extended coverage applies only to an Inpatient Stay.

## Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

## **Qualifying Events for Continuation Coverage under State Law**

To qualify for continuation coverage under state law, the Covered Person must meet the criteria below:

- The Covered Person was enrolled, for a period of at least six months immediately prior to termination of coverage, for coverage under the Policy or under any other group plan that was replaced by the Policy that provided Benefits similar to Benefits under the Policy.
- The Covered Person is not enrolled in Medicare or Medicaid.

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group.
- Reduction in the Subscriber's hours to less than 40 hours a week as a result of economic conditions.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.

Continuation of coverage is subject to the Policy (or a successor policy) remaining in force and the Premium being paid according to the terms of the Policy. If the Covered Person's coverage terminated due to one of the qualifying events listed above, he or she is entitled to continuation coverage under state law.

## **Notification Requirements and Election Period for Continuation Coverage under State Law**

The Enrolling Group will provide you with written notification of the right to continuation coverage within 10 days of when coverage ends under the Policy. You must elect continuation coverage within:

- 30 days after the qualifying event, if the plan administrator provides written notice of the right to continue; or
- 60 days after the qualifying event occurs, if the plan administrator does not provide written notice of the right to continue.

You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

## **Terminating Events for Continuation Coverage under State Law**

Continuation coverage under the Policy will end on the earliest of the following dates:

- 18 months from the date your continuation began.
- The date you no longer live or work within the Service Area.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is obtained under any other group health plan which does not contain a preexisting limitation or exclusion for any condition which is covered under the Policy.
- The date you become covered by Medicare.
- The date you become covered by Medicaid.
- The date the Policy ends.

## **Conversion**

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- If the Policy under which you are entitled is issued to an Enrolling Group that has 50 or fewer employees, you may also apply for conversion coverage without furnishing evidence of insurability if the entire Policy is terminated and not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

## Section 5: How to File a Claim

### If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

### If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

### Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

### Payment of Benefits

We will pay Benefits within 45 days for paper claims and 30 days for electronic claims after we receive your request for payment that includes all required information.

You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-

Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

## **Section 6: Questions, Complaints and Appeals**

### **What to Do if You Have a Question**

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

### **What to Do if You Have a Complaint**

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

### **How to Appeal a Claim Decision**

#### **Post-service Claims**

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

#### **Pre-service Requests for Benefits**

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care.

#### **How to Request an Appeal**

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or 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 by a Physician 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.

## Appeals Determinations

### Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your 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 no later than 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of pre-service request, if you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your second level appeal request must be submitted to us within 30 days from receipt of the first level appeal decision. The second level appeal review meeting, by either a health care professional or review panel of health care professionals, as appropriate, will be conducted within 60 days of receipt of the request for a voluntary second level review. These reviewer(s) will not have a direct financial interest in the outcome of the review. You will be notified in writing at least 20 days in advance of the date of the review meeting. You will be notified in writing of the decision within seven days of completion of the review meeting.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision no later than 30 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims as identified above, if you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your second level appeal request must be submitted to us within 30 days from receipt of the first level appeal decision. The second level appeal review meeting, by either a health care professional or review panel of health care professionals, as appropriate, will be conducted within 60 days of receipt of the request for a voluntary second level review. These reviewer(s) will not have a direct financial interest in the outcome of the review. You will be notified in writing at least 20 days in advance of the date of the review meeting. You will be notified in writing of the decision within seven days of completion of the review meeting.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That 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.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

## **Independent External Review Program**

After you exhaust at least one level of the appeal process, if we make a final determination to deny Benefits, you may choose to participate in the independent external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits unless the member presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.

You or your representative must file a request for independent external review no later than 60 calendar days after you have received notification of the appeal decision. Your written request for an independent external review must include a completed external review request form specified by the *Office of the Commissioner of Insurance* as well as a signed consent authorizing us to disclose your medical records. New information may be submitted with the request if it is significantly different from the information provided or considered during the internal appeal process.

We will submit a copy of your request to the *Office of the Commissioner of Insurance*, who will select an independent external review entity. The independent external review entity will determine whether to uphold or reverse our appeal decision within 30 working days of receipt of the request for external review. For expedited reviews, the independent external review entity will determine whether to uphold or reverse our appeal decision within seven working days of receipt of the request for external review.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

## Section 7: Coordination of Benefits

### Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

### When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

### Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
  2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after

those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
  2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
  3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
  5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## **Order of Benefit Determination Rules**

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

- D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
  - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
  - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
    - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
    - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
    - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

- (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - (a) The Plan covering the Custodial Parent.
      - (b) The Plan covering the Custodial Parent's spouse.
      - (c) The Plan covering the non-Custodial Parent.
      - (d) The Plan covering the non-Custodial Parent's spouse.
    - c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
  3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
  4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
  5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
  6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

## **Effect on the Benefits of This Plan**

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

## **Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

## **Payments Made**

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## **Right of Recovery**

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## **When Medicare is Secondary**

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

## Section 8: General Legal Provisions

### Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

### Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.



## **Your Relationship with Providers and Enrolling Groups**

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

## **Notice**

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

## **Notice of Continuation**

In the event of termination of employment, the Enrolling Group will give eligible Subscribers written notice that continuation of coverage under the Enrolling Group's Policy is available. The Enrolling Group will give notice of continuation within 10 days of the date coverage would end. The notice will include the following:

- Notice of the Subscriber's right to continue group coverage.
- The amount of the payments needed to continue coverage.
- Where, when, and how to make payments.

## **Notice of Conversion**

In the event of termination of coverage, a Subscriber who is entitled to make application for conversion coverage will be given written notice of the conversion privilege at least 15 days prior to the expiration of the 31-day conversion period. If the Subscriber is not given notice of his/her conversion rights, the Subscriber will have an additional period within which to make application. This additional period will expire 15 days after the Subscriber has been given the written notice, but in no event will the additional period be continued for more than 60 days after the expiration of the 31-day conversion period established by the Policy. Written notice presented by the Enrolling Group or mailed by the Enrolling Group to the last known address of the Subscriber (as furnished to the Enrolling Group), will constitute the giving of notice for the purpose of this provision. If the Enrolling Group is a small employer group, as defined by Colorado law, we are responsible for providing notice of conversion rights.

## Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years. No statement will be used to void or reduce coverage under the Policy or be used in defense of a legal action, unless it is contained in a written application.

## Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

## Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

## Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any Annual Deductible or taken into account in determining your Copayments or Coinsurance.

## Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.

- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

## **Administrative Services**

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## **Amendments to the Policy**

To the extent permitted by law, we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

## **Information and Records**

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format

for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

## **Examination of Covered Persons**

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

## **Workers' Compensation not Affected**

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## **Subrogation and Reimbursement**

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.

- Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
  - That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
  - That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
  - That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
  - That benefits paid by us may also be considered to be benefits advanced.
  - That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
  - That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
  - That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
  - That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
  - That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
  - That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
  - That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
  - That we shall not be obligated in any way to pursue this right independently or on your behalf.
  - That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
  - That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

## Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

## Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

## Section 9: Defined Terms

**A Recommendation** - means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

**B Recommendation** - means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

**Alternate Facility** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

**Amendment** - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

**Annual Deductible** - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

**Applied Behavioral Analysis** - includes the use of behavioral analytic methods and research findings to change socially important behaviors in meaningful ways.

**Autism Spectrum Disorders or (ASD)** - includes the following neurobiological disorders: *autistic disorder; Asperger's Disorder* and *Atypical Autism* as a diagnosis with *Pervasive Development Disorder Not Otherwise Specified (PDDNOS)*, as defined in the most recent addition of the *Diagnostic and Statistical Manual of Mental Disorders*, at the time of the diagnosis.

**Benefits** - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

**Biologically Based Mental Illnesses** - the following conditions as described in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.

**Child Health Supervision Services** - those preventive services and immunizations required to be provided to dependent children up to age 13 as follows:

- 0 - 12 months: One newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours following delivery; six well-child visits; one PKU testing.
- 13 - 35 months: Three well-child visits.

- 3 - 6 years: Four well-child visits.
- 7 - 12 years: Four well-child visits.
- 0 - 12 years: Immunizations. Immunization deficient children are not bound by "recommended ages".

**Clinical Trial** - an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

**Coinsurance** - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

**Congenital Anomaly** - a physical developmental defect that is present at the time of birth.

**Copayment** - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

**Covered Health Service(s)** - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

**Covered Person** - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

**Custodial Care** - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Dependent** - the Subscriber's legal spouse, Common Law Spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.



- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes medically certified as disabled and dependent upon the Subscriber or the Subscriber's spouse.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

**Designated Facility** - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Designated Network Benefits** - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

**Designated Physician** - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Disability or Disabled** - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation and a Dependent's inability to perform the normal activities of a person of like age and sex.

**Domestic Partner** - a person of the same sex with whom the Subscriber has established a Domestic Partnership.

**Domestic Partnership** - a relationship between a Subscriber and one other person of the same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.

- They must be mentally competent to consent to contract.
- They must be financially interdependent.

**Durable Medical Equipment** - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, 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 (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Please refer to [www.myuhc.com](http://www.myuhc.com) or call the telephone number for *Customer Care* listed on your ID card for more information.

**Eligible Person** - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

**Emergency** - a sudden and, at the time, unexpected onset of a health condition that a prudent lay person would assume requires immediate attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

**Emergency Health Services** - health care services and supplies necessary for the treatment of an Emergency.

**Enrolled Dependent** - a Dependent who is properly enrolled under the Policy.

**Enrolling Group** - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use except that Benefits are provided for Prescription Drug Products that have been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials and Studies in Section 1: Covered Health Services*.
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Genetic Testing** - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

**Home Health Agency** - a program or organization authorized by law to provide health care services in the home.

**Hospital** - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

**Initial Enrollment Period** - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

**Injury** - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility** - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intensive Outpatient Treatment** - a structured outpatient mental health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care** - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

**Manipulative Treatment** - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medically Necessary** - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

*Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled Clinical Trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

**Medicare** - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Mental Disorder** - means post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient day treatment, and inpatient basis, exclusive of residential treatment. Mental disorders will not be subject to the limitations of Mental Health Services as described above.

**Mental Health Services** - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder Designee** - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

**Mental Illness** - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

**Non-Network Benefits** - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

**Open Enrollment Period** - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

**Partial Hospitalization/Day Treatment** - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Pharmaceutical Product(s)** - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

**Pharmaceutical Product List** - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

**Pharmaceutical Product List Management Committee** - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

**Physician** - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, anesthesiologist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

**Policy** - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

**Policy Charge** - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

**Pregnancy** - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

**Premium** - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

**Primary Physician** - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Private Duty Nursing** - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

**Residential Treatment Facility** - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

**Rider** - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

**Routine Patient Care Costs** - all items and services that would be covered if the Covered Person were not involved in either the experimental or the control arms of a Clinical Trial; except the investigational item or service itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any Covered Person in the trial; routine costs in Clinical Trials that include items or services that are typically provided absent a Clinical Trial; items or services required solely for the provision of the investigational items or services; the clinically appropriate monitoring of the effects of the item or service; the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

**Skilled Nursing Facility** - a Hospital or nursing facility that is licensed and operated as required by law.

**Specialist Physician** - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Subscriber** - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Task Force** - means the *U.S. Preventive Services Task Force* or any successor organization, sponsored by the *Agency for Healthcare Research and Quality*, the *Health Services Research Arm* of the federal *Department of Health and Human Services*.

**The Advisory Committee on Immunization Practices (ACIP)** - means the advisory committee on immunization practices to the *Centers for Disease Control and Prevention* in the *Federal Department of Health and Human Services*, or any successor entity.

**Transitional Care** - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Unproven Service(s)** - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com](http://www.myuhc.com).

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Urgent Care Center** - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.



## Standard Section Names

As required by Colorado Regulation 4-2-34, effective January 1, 2012, the purpose of the chart below is to:

- Provide a standardized format for section names in Policy forms issued by health carriers.
- Provide a directory cross-referencing the standard section names (left column) with those section names that currently appear in UnitedHealthcare's Policy forms (right column).

<b>Standard Section Names as required by Colorado Regulation 4-2-34</b>	<b>UnitedHealthcare Current Section Names</b>
Schedule of Benefits (Who Pays What)	Schedule of Benefits
Title Page (Cover Page)	Title Page (Cover Page)
Contact Us	<ul style="list-style-type: none"> <li>• Certificate of Coverage Cover Page</li> <li>• Certificate of Coverage - <i>Introduction to Your Certificate: Don't Hesitate to Contact Us</i></li> </ul>
Table of Contents	Certificate of Coverage: <i>Table of Contents</i>
Eligibility	Certificate of Coverage: <i>Section 3: When Coverage Begins</i>
How to Access Your Services and Obtain Approval of Benefits	Schedule of Benefits: <i>Accessing Benefits</i>
Benefits/Coverage (What is Covered)	Certificate of Coverage - <i>Section 1: Covered Health Services</i>
Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)	Certificate of Coverage - <i>Section 2: Exclusions and Limitations</i>
Member Payment Responsibility	Schedule of Benefits - <i>Benefits</i>
Claims Procedures (How to File a Claim)	Certificate of Coverage - <i>Section 5: How to File a Claim</i>
General Policy Provisions	Group Policy - <i>Article 6: General Provisions</i>
Termination/Nonrenewal/Continuation	Certificate of Coverage - <i>Section 4: When Coverage Ends</i>
Appeals and Complaints	Certificate of Coverage - <i>Section 6: Questions, Complaints and Appeals</i>
Information on Policy and Rate Changes	Group Policy - <i>Article 3: Premium Rates and Policy Charge</i>
Definitions	Certificate of Coverage - <i>Section 9: Defined Terms</i>

# Home Health Care and Hospice Care Amendment

## UnitedHealthcare Insurance Company

Because this Amendment reflects changes in requirements of insurance law of the State of Colorado, 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 Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and this Amendment below.

1. Home Health Care and Hospice Care in the *Certificate, Section 1: Covered Health Services* are replaced with the following:

### Home Health Care

Home health care services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered and licensed nurse, certified nurse aid or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent schedule and when skilled care is required. Home health services are to be covered when services are necessary as alternatives to hospitalization, or in place of hospitalization. Prior hospitalization is not required.

Home health care visits may be included but are not limited to:

- Skilled nursing visits;
- Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the member's illness or Injury;
- Physical, occupational, or speech therapy and language therapy, including audiology services, that is provided on a per visit basis;
- Respiratory and inhalation therapy;
- Nutrition counseling by a nutritionist or dietitian;
- Enteral feedings (tube feedings);
- Medical supplies, Durable Medical Equipment as described under Durable Medical Equipment in the *Certificate* under *Section 1: Covered Health Services*; and
- Infusion therapy medications and supplies and laboratory services as prescribed by a provider to the extent such services would be covered by us had the member remained in the hospital, rehabilitation or Skilled Nursing Facility.
- "Social work practice services" are those services provided by a licensed social worker who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at

the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by a registered or licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

## **Hospice Care**

Hospice services are covered for members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six months or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the member's interdisciplinary team, which includes, but is not limited to, the member, the member's Physician, a registered nurse, a social worker and a spiritual caregiver.

Benefits are available when hospice services are received from a hospice agency that is licensed and regulated by the Colorado Department of Public Health and Environment.

Hospice services include:

- Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse and nursing services delegated to other assistants.
- Bereavement support services
- Psychosocial services/counseling services.
- Medical direction.
- Volunteer services.
- Drugs and biologicals.
- Prosthesis and orthopedic appliances.
- Oxygen and respiratory supplies.
- Diagnostic testing.
- Rental or purchase of durable equipment.
- Transportation.
- Nutritional counseling by a nutritionist or dietitian.

- Medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions.
- Physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the member to maintain activities of daily living and basic functional skills.
- Pastoral services.

Covered hospice services are available in the home on a 24-hour basis during periods of crisis, when a member requires continuous care to achieve palliation or management of acute medical symptoms. Home is defined as a place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. Inpatient hospice services are provided in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the member ("respite care"). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

2. Hospice Care in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Hospice Care			
	100%	No	No

3. The exclusion in the *Certificate* under *Section 2: Exclusions and Limitations*, Nutrition is replaced with the following:

## J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition, except for the first 31 days of life. Benefits for medical foods are described under the *Outpatient Prescription Drug Rider*.
3. Enteral feedings (tube feedings), except when provided as part of a Home Health Care plan of care provided or arranged for by a Home Health Agency, as described under Home Health Care in the *Certificate* under *Section 1: Covered Health Services*.
4. Infant formula and donor breast milk.

5. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
6. The definition of Physician in the *Certificate* under *Section 9: Defined Terms* is replaced with the following:

**Physician** - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, anesthesiologist, acupuncturist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Domestic Partner Amendment

## UnitedHealthcare Insurance Company

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and this Amendment below.

1. The definitions of Domestic Partner and Domestic Partnership in the *Certificate* under *Section 9: Defined Terms* are replaced with the following:

**Domestic Partner** - a person with whom the Subscriber has established a Domestic Partnership.

**Domestic Partnership** - a relationship between a Subscriber and one other person. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must be financially interdependent.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Health Resources and Services Administration (HRSA) Amendment

## UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

### Benefits for Breast Pumps

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. These Benefits are provided as described under *Preventive Care Services* in the *Certificate, Section 1: Covered Health Services* and in the *Schedule of Benefits*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

As a result of this requirement, the exclusion for supplies, equipment and similar incidental services and supplies for personal comfort in *Section 2: Exclusions and Limitations* under *Personal Care, Comfort or Convenience* is replaced with the following:

### Personal Care, Comfort or Convenience

Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

- Air conditioners, air purifiers and filters and dehumidifiers.
- Batteries and battery chargers.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.

- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jeffrey Alter", is positioned above the printed name.

Jeffrey Alter, President



# Questions, Complaints and Appeals Amendment

## UnitedHealthcare Insurance Company

The Policy is modified as described in this Amendment.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

*The provisions in the Certificate under Section 6: Questions, Complaints and Appeals, are replaced with the following:*

### Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

#### What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

#### What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

#### How to Appeal a Claim Decision

##### Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

##### Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care.

#### How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

## 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 by a Physician with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Determination.

## Appeals Determinations

### Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your 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. If you are not satisfied with the first level appeal decision, you may be entitled to request an independent external review as described below, or if the Benefit denial involves an Adverse Determination based on clinical criteria, a Rescission, or a denial of coverage based on an initial eligibility determination, you have the right to request a voluntary second level review. Your voluntary second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. A voluntary second level review will be conducted within 15 days of receipt of the request by a health care professional (reviewer) who was not previously involved in the appeal and who does not have a direct financial interest in the appeal or outcome of the review. You have the right to appear in person or by telephone conference at the voluntary second level review meeting and will be notified in advance of the date of the meeting. Within 7 days of completion of the review meeting, but no later than 15 days of receipt of the voluntary second level review request, you will receive written notification of the decision on your appeal.
- 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. If you are not satisfied with the first level appeal decision, you may be entitled to request an independent external review as described below, or if the Benefit denial involves an Adverse Determination based on clinical criteria, a Rescission, or a denial of coverage based on an initial

eligibility determination, you have the right to request a voluntary second level appeal. Your voluntary second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. A voluntary second level review will be conducted within 30 days of receipt of the request by a health care professional (reviewer) who was not previously involved in the appeal and who does not have a direct financial interest in the appeal or outcome of the review. You have the right to appear in person or by telephone conference at the voluntary second level review meeting and will be notified in advance of the date of the meeting. Within 7 days of completion of the review meeting, but no later than 30 days of receipt of the voluntary second level review request, you will receive written notification of the decision on your appeal.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an independent external review entity upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

## **Urgent Appeals that Require Immediate Action**

Your appeal may require 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.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.
- If additional information is needed from you to make a decision, we will notify you of the information required within 24 hours after the urgent request is 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.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

## **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, 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.

## Independent External Review Program

If, after the completion or exhaustion of the internal appeal process, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations, you may be entitled to request an independent external review of our Adverse Determination. If you are enrolled under a wellness and prevention program that provides incentives or rewards for satisfaction of a standard related to a health risk factor, you may also request an independent external review of our denial of a request for an alternate standard or waiver of a standard otherwise applicable to you under the wellness program.

If one of the above conditions is met, you or your designated representative may request an independent external review of an Adverse Determination based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

There is no minimum dollar amount for a claim to be eligible for an independent external review.

The independent external review program is not available if our coverage determination is based on a Benefit exclusion or defined Benefit limit unless you present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.

You or your designated representative may request an independent external review by sending a written request to the address set out in the Adverse Determination letter:

- Within four months after you receive notification of our final Adverse Determination following the completion or exhaustion of the internal appeal process.
- At the same time as you request an internal urgent appeal if you are requesting a concurrent expedited external review.

An independent external review request must include all of the following:

- A completed external review request form as specified by the *Office of the Commissioner of Insurance*.
- A signed consent form authorizing us to disclose the Covered Person's protected health information, including medical records, that is pertinent to the external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided or considered during the internal appeal process.
- For an expedited external review request, a Physician's certification that the Covered Person has a medical condition for which application of the time period for completion of the internal urgent appeal process or the standard external review process would seriously jeopardize the Covered

Person's life, health, or ability to regain maximum function, or for Covered Persons with a disability, would create an imminent and substantial limitation of their existing ability to live independently.

- For an external review request involving a service that is Experimental or Investigational, certification from the treating Physician that the recommended or requested health care service or treatment will be less effective if not begun immediately, and that:
  - Standard health care services or treatments have not improved the Covered Person's condition or are not medically appropriate for the Covered Person; or
  - There is no standard health care service or treatment available that is covered under the Policy and is more beneficial to the Covered Person than the recommended or requested health care service or treatment, and that the Physician is a board-certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Covered Person's condition.

The Physician must also certify that scientifically valid studies support the health care service or treatment subject to the denial is likely to be more beneficial to the Covered Person than any available standard health care services or treatments.

If your request qualifies for an independent external review, our denial decision will be reviewed by an independent external review entity selected by the *Office of the Commissioner of Insurance*. We will pay the costs of the independent external review.

**Standard Independent External Review Request:** Your request for an independent external review must be submitted to us in writing within four months of the date you received notice of our Adverse Determination following the completion or exhaustion of the internal appeal process.

1. Within two business days of receipt of your request for an independent external review, we will forward a copy of the request to the *Office of the Commissioner of Insurance* who will select an independent external review entity. If we deny your eligibility for independent external review, we will notify you, your designated representative, and the *Office of the Commissioner of Insurance* in writing with the specific reasons for the denial and information about appealing that determination to the *Office of the Commissioner of Insurance*.
2. If your request is eligible for review, the *Office of the Commissioner of Insurance* will assign an independent external review entity and will notify us of the name and address of the entity within two business days of receipt of the independent external review request.
3. Within one business day of receipt of the *Office of the Commissioner of Insurance's* notice of assignment to an independent external review entity, we will notify you and your designated representative in writing of the name and address of the independent external review entity.
4. Within five business days of the date you receive notice of assignment to an independent external review entity, you or your designated representative may submit any additional information in writing to the independent external review entity that you want the entity to consider in its review.
5. The independent external review entity will conduct its review and will provide written notice of its decision to you and your designated representative, to us, and to the *Office of the Commissioner of Insurance* within 45 calendar days after receipt of the independent external review request.
6. Upon receipt of notice from the independent external review entity that our denial decision is overturned, we will approve coverage of the Covered Health Service that was the subject of the review:
  - Within one business day for concurrent and prospective reviews of pre-service requests for Benefits.
  - Within 5 business days for retrospective reviews of post-service claims.

We will provide written notice of the approval to you and your designated representative within one business day of our approval of coverage. Coverage will be provided in accordance with the terms and conditions of the Policy.

**Expedited Independent External Review Request:** You may file a request for an expedited independent external review at the same time as you file an internal urgent appeal of a prospective or concurrent service denial of Benefits if the Covered Person has a medical condition for which application of the time period for completion of the internal urgent appeal process or the standard external review process would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function, or for Covered Persons with a disability, would create an imminent and substantial limitation of their existing ability to live independently.

An expedited independent external review request must include a Physician's certification that the Covered Person's medical condition meets the above criteria.

An expedited independent external review will not be provided for post-service claim denials or for denials of a request for an alternate standard or waiver of a standard applicable to a Covered Person under an applicable wellness and prevention program.

1. Within one business day of receipt of your request for an expedited independent external review, we will forward a copy of the request to the *Office of the Commissioner of Insurance* who will select an independent external review entity. If we deny your eligibility for independent external review, we will notify you, your designated representative, and the *Office of the Commissioner of Insurance* in writing with the specific reasons for the denial and information about appealing that determination to the *Office of the Commissioner of Insurance*.
2. If your request is eligible for review, the *Office of the Commissioner of Insurance* will assign an independent external review entity and will notify us of the name and address of the entity within one business day of receipt of the expedited independent external review request.
3. Within one business day of receipt of the *Office of the Commissioner of Insurance's* notice of assignment to an independent external review entity, we will notify you and your designated representative in writing of the name and address of the independent external review entity.
4. Upon receipt of notice of assignment to an independent external review entity, you or your designated representative may submit any additional information in writing to the independent external review entity that you want the entity to consider in its review.
5. The independent external review entity will conduct its review and will provide notice of its decision to you and your designated representative, to us, and to the *Office of the Commissioner of Insurance* within 72 hours after receipt of the expedited independent external review request. If notice of the independent external review entity's decision is not in writing, the independent external review entity will provide written confirmation of its decision within 48 hours after the date of providing that notice.
6. Immediately upon receipt of notice from the independent external review entity that our denial decision is overturned, we will approve coverage of the Covered Health Service that was the subject of the review and will provide written notice of the approval to you and your designated representative. Coverage will be provided in accordance with the terms and conditions of the Policy.

**Binding Nature of the Independent External Review Decision:** The independent external review decision is binding on both you and us except to the extent that other remedies may be available under federal or state law.

You or your designated representative may not file a subsequent request for an independent external review involving the same determination for which the Covered Person has already received an independent external review decision.

You may contact us at the toll-free number on your ID card for more information regarding external review rights.

## Section 9: Defined Terms

*The definition of Rescission is added and the definition of Adverse Determination is replaced with the following in the Certificate under Section 9: Defined Terms:*

**Adverse Determination** - means a determination by us or our designee that a request for a pre-service or post-service Benefit has been reviewed and, based upon the information provided, does not meet the definition of Medically Necessary, or that the Benefit is not appropriate, effective, efficient, is not provided in or at the appropriate health care setting or level of care, or is determined to be an Experimental or Investigational Service, and is therefore denied, reduced or terminated. An Adverse Determination also includes a denial for a Benefit excluded by this Policy for which the Covered Person is able to present evidence from a medical professional that there is reasonable medical basis that the contractual exclusion does not apply to the denied Benefit. An Adverse Determination also includes a rescission or cancellation of coverage not attributed to a failure to pay Premiums that is applied retroactively, as well as a denial of coverage to a Covered Person based on an initial eligibility determination, however, a Physician is not required to evaluate an appeal of these types of Adverse Determinations. For the Independent External Review process, this definition also includes a denial of a request for an alternate standard or waiver of a standard that would otherwise be applicable to a Covered Person under an applicable wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor.

**Rescission** - the cancellation or discontinuance of coverage that has a retrospective effect. This includes a cancellation that treats a Policy as void from the time of enrollment, and a cancellation that voids Benefits paid up to a year before the cancellation takes place. A Rescission of coverage shall be treated as an Adverse Determination. A cancellation or discontinuance of coverage is not a Rescission if the cancellation or discontinuance is exclusively prospective, or the cancellation or discontinuance is retroactive only to the extent attributable to a failure to pay Premiums or contributions toward the cost of coverage in a timely manner.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Clinical Trials, Civil Unions and Patient Protection and Affordable Care Act (PPACA) Related 2014 Provisions Amendment

## UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below. This Amendment is applicable to Policies issued in the state of Colorado.

Because this Amendment reflects changes in requirements of state and 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 Covered Person 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* are replaced as described below:

### Section 1: Covered Health Services

*Clinical Trials in Section 1: Covered Health Services is replaced with the following:*

#### Clinical Trials

Routine patient care costs that a Covered Person receives during a clinical trial will be covered if:

- The Covered Person's provider recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person;
- The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended;
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
- Prior to participation in a clinical trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the clinical trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the Covered Person's health benefit plan, and all out-of-network rates will apply; and
- The Covered Person suffers from a condition that is disabling, progressive, or life-threatening.

Routine patient care costs for qualifying clinical trials include:



- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine patient care costs for clinical trials do not include:

- Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
- Costs for the management of research relating to the clinical trial or study; or
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Covered Person's health plan.

"Clinical trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

"Routine patient care cost" means all items and services that are a benefit under a health coverage plan that would be covered if the Covered Person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

## 2. Civil Unions

### Section 3: When Coverage Begins

*The Adding New Dependents and Special Enrollment Period provisions in Section 3: When Coverage Begins are replaced with the following:*

#### **Adding New Dependents**

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.

- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Partner in a Civil Union.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Newborns are covered for the first 31 days of life. If a specific Premium is required to provide coverage for the newborn, you must submit a completed enrollment form to us prior to the expiration of the 31-day period for coverage to continue beyond the first 31 days of life. If no additional Premium is required to provide coverage for the newborn, you are required to submit a completed enrollment form to us prior to the expiration of the 31-day period.

### **Special Enrollment Period**

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Permanent legal guardianship.
- Court or administrative order.
- Registering a Partner in a Civil Union.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

### 3. Defined Terms

## Section 9: Defined Terms

*In Section 9: Defined Terms, the definitions of Civil Union and Partner in a Civil Union are added and the definitions of Dependent and Experimental or Investigational Service(s) are replaced with the following:*

**Civil Union** - means a relationship established by two eligible persons in accordance with Colorado law for the purpose of entitling them to receive the benefits and protections and be subject to the responsibilities of spouses. A civil union will be legally recognized if:

- The two parties to the civil union satisfy all of the following criteria:
  - Both parties are adults, regardless of the gender of either party;
  - Neither party is a party to another civil union;
  - Neither party is married to another person;
  - The parties are not related to each other as an ancestor, descendant, brother, sister, uncle, aunt, niece, or nephew, whether the relationship is by the half or the whole blood.

- Neither party is under 18 years of age or 18 years of age or older and under guardianship, unless the party under guardianship has the written consent of his or her guardian.
- The civil union is certified and registered with a county clerk and recorder in the State of Colorado.

**Dependent** - the Subscriber's legal spouse, Common Law Spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Partner in a Civil Union and a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes medically certified as disabled and dependent upon the Subscriber or the Subscriber's spouse.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

**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, except that Benefits are provided for Prescription Drug Products that have been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.
- 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* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, 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 Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Partner in a Civil Union** - means a person who has established a Civil Union certified and registered with a county clerk and recorder in the State of Colorado.

## **2. Additional Patient Protection and Affordable Care Act (PPACA) Related 2014 Provisions**

### **Durable Medical Equipment**

Benefits for Durable Medical Equipment are not subject to the annual dollar limit stated in the *Schedule of Benefits*, however Benefits continue to be subject to the limitation of a single purchase of a type of DME (including repair/replacement) every three years.

### **Prosthetic Devices**

Benefits for prosthetic devices are not subject to the annual dollar limit stated in the *Schedule of Benefits*, however Benefits continue to be subject to the limitation of a single purchase of each type of prosthetic device every three years.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Outpatient Prescription Drug

## UnitedHealthcare Insurance Company

### Schedule of Benefits

#### Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, Depo Provera and other injectable drugs.

#### If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

#### Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

#### Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician or your pharmacist are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require either your Physician or your pharmacist to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

## **Network Pharmacy Prior Authorization**

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider or the pharmacist are responsible for obtaining prior authorization from us.

The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

## **Step Therapy**

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

## **What You Must Pay**

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

## Payment Information

Payment Term And Description	Amounts
<p><b>Copayment and Coinsurance</b></p>	
<p><b>Copayment</b></p> <p>Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.</p> <p><b>Coinsurance</b></p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p><b>Copayment and Coinsurance</b></p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p><b>Special Programs:</b> We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p><b>Prescription Drug Products Prescribed by a Specialist Physician:</b> You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p><b>NOTE:</b> The tier status of a Prescription</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment and/or Coinsurance.</li> <li>• The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.</li> </ul> <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment and/or Coinsurance.</li> <li>• The Prescription Drug Charge for that Prescription Drug Product.</li> </ul> <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.</p>



<b>Payment Term And Description</b>	<b>Amounts</b>
<p>Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p>	

## Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p><b>Specialty Prescription Drug Products</b></p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier-1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$20.00 per Prescription Order or Refill.</p> <p>For a Tier-2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$40.00 per Prescription Order or Refill.</p> <p>For a Tier-3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$60.00 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.</p> <p>Benefits for oral chemotherapeutic agents are not subject to payment of the Annual Drug Deductible.</p>
<p><b>Prescription Drugs from a Retail Network Pharmacy</b></p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</li> <li>A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.</li> </ul> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$20.00 per Prescription Order or Refill.</p> <p>For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$40.00 per Prescription Order or Refill.</p> <p>For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of</p>

<b>Description and Supply Limits</b>	<b>Benefit (The Amount We Pay)</b>
consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	<p>\$60.00 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.</p>
<b>Prescription Drug Products from a Mail Order Network Pharmacy</b>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>.</li> </ul> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For up to a 90-day supply, we pay:</p> <p>For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$50.00 per Prescription Order or Refill.</p> <p>For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$100.00 per Prescription Order or Refill.</p> <p>For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$150.00 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.</p>

# Outpatient Prescription Drug Rider

## UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# Introduction

## Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com](http://www.myuhc.com) through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

## Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

## Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

## **Limitation on Selection of Pharmacies**

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

## **Rebates and Other Payments**

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

## **Coupons, Incentives and Other Communications**

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

## **Special Programs**

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

## **Prescription Drug Products Prescribed by a Specialist Physician**

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

# **Outpatient Prescription Drug Rider Table of Contents**

<b>Section 1: Benefits for Prescription Drug Products.....</b>	<b>11</b>
<b>Section 2: Exclusions.....</b>	<b>12</b>
<b>Section 3: Defined Terms.....</b>	<b>14</b>

# Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, Depo Provera and other injectable drugs.

## Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

## Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

## Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access [www.myuhc.com](http://www.myuhc.com) through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.



## Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com](http://www.myuhc.com) through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This does not include Prescription Drug Products that have been approved by the *U.S. Food and Drug Administration (FDA)* for use in the treatment of cancer but have not been approved by the *FDA* for the treatment of the specific type of cancer for which the drug is prescribed if:
  - The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the *U.S. Department of Health and Human Services*; and
  - The treatment is for a Covered Health Service.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
13. Unit dose packaging of Prescription Drug Products.
14. Medications used for cosmetic purposes.

15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility.
18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. 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 for Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders, as specified in *Section 3, Defined Terms* of this Rider.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. 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.
25. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

## Section 3: Defined Terms

**Brand-name** - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

**Chemically Equivalent** - when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

**Generic** - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

**Inherited Enzymatic Disorder** - a disorder caused by single gene defects involved in the metabolism of amino, organic, and fatty acids including, but not limited to the following diagnosed conditions:

- Phenylketonuria in female Covered Persons who are less than 21 years of age.
- Maternal phenylketonuria in female Covered Persons of child bearing age who are less than 35 years old.
- Maple syrup urine disease.
- Tyrosinemia.
- Homocystinuria.
- Urea cycle disorders.
- Hyperlysinemia.
- Glutaric acidemias.
- Methylmalonic ademia.
- Propionic acidemia.

**Medical Foods** - prescription metabolic formulas and their modular counterparts that are:

- Obtained through a pharmacy.
- Specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist.
- Specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a Physician.

The term "Medical Foods" does not include foods for cystic fibrosis patients or lactose or soy intolerant patients.

**Network Pharmacy** - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

**Prescription Drug Charge** - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

**Prescription Drug List** - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

**Prescription Drug List (PDL) Management Committee** - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

**Prescription Drug Product** - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

**Prescription Order or Refill** - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Preventive Care Medications** - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

**Therapeutically Equivalent** - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

# Routine Vision Examination Rider

## UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for routine vision examinations, as described below.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

## Section 1: Benefits for Routine Vision Examinations

Benefits are available for Vision Care Services from a Network Vision Care Provider. To find a Network Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Network Vision Care Providers on the Internet at [www.myuhcvision.com](http://www.myuhcvision.com).

When obtaining these Vision Care Services from a Network Vision Care Provider, you will be required to pay any Copayments at the time of service.

### 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-Pocket Maximum** - any amount you pay in Coinsurance 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 Copayments for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

## Benefit Description

### Benefits

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

### Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Copayments and Coinsurance stated 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.

Vision Care Service	Frequency of Service	Benefit
<i>Routine Vision Examination or Refraction only in lieu of a complete exam.</i>	Once every 24 months.	100% after a Copayment of \$30.

## Section 2: Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Routine Vision Examinations*, 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. Vision Care Services received from a non-Network Vision Care Provider.

## Section 4: Defined Terms

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate*:

**Vision Care Provider** - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

**Vision Care Service(s)** - routine vision examinations listed in this Rider in *Section 1: Benefits for Routine Vision Examinations*.



# 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.

## 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). Under the *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*.

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, 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.

**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 the back of 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 the back of 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 the back of 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 the back of 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 the back of 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](http://www.healthcare.gov).

## **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 July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health 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.

## **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 Annual 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 September 23, 2013*

We<sup>1</sup> 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, we will post the revised notice on your health plan website such as [www.myuhc.com](http://www.myuhc.com) or [www.uhcwest.com](http://www.uhcwest.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.
- **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, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **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 the back of your 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](http://www.myuhc.com) or [www.uhcwest.com](http://www.uhcwest.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 the back of your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center Representative* at 866-633-2446.
- **Submitting a Written Request.** Mail to us 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, 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.

<sup>1</sup>*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 Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, 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.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, 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 New York, Inc.; Physicians Health Choice of Texas, LLC; Preferred Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, 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 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 AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

*Effective September 23, 2013*

We<sup>2</sup> 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

We 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 consumer reports.

### 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 communications on our behalf.

### Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

### Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on the back of your health plan ID card or contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.

<sup>2</sup>For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on page XV of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network,



*Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; ProcessWorks, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; 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.; UnitedHealthOne Agency, 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: June 30, 2013

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:

- Show the categories of health information that are subject to these more restrictive laws; and
- 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

<b>Alcohol &amp; Drug Abuse Information</b>	
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.	
<b>Genetic Information</b>	
We are not allowed to use genetic information for underwriting purposes.	

### Summary of State Laws

<b>General Health Information</b>	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, 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.	MO, NJ, SD
<b>Prescriptions</b>	
We are allowed to disclose prescription-related information only (1) under certain limited	ID, NH, NV

circumstances, and /or (2) to specific recipients.	
<b>Communicable Diseases</b>	
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
<b>Sexually Transmitted Diseases and Reproductive Health</b>	
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
<b>Alcohol and Drug Abuse</b>	
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.	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
<b>Genetic Information</b>	
We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, 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, 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
<b>HIV / AIDS</b>	
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
<b>Mental Health</b>	
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
<b>Child or Adult Abuse</b>	
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, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI







# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
04/17/2015

**THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.**

**IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).**

<b>PRODUCER</b> MARSH USA INC. 333 SOUTH 7TH STREET, SUITE 1400 MINNEAPOLIS, MN 55402-2427 Attn: Healthcare.AccountsCSS@Marsh.com/FAX 212-948-1307  401115-5M--GAWX5-15-16	<b>CONTACT NAME:</b> <b>PHONE (A/C, No. Ext):</b> <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b>  <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;">INSURER(S) AFFORDING COVERAGE</th> <th style="width: 20%;">NAIC #</th> </tr> </thead> <tbody> <tr> <td><b>INSURER A:</b> Old Republic Insurance Company</td> <td>24147</td> </tr> <tr> <td><b>INSURER B:</b> American Guarantee &amp; Liability Ins Co</td> <td>26247</td> </tr> <tr> <td><b>INSURER C:</b> Travelers Property Casualty Company of America</td> <td>25674</td> </tr> <tr> <td><b>INSURER D:</b></td> <td></td> </tr> <tr> <td><b>INSURER E:</b></td> <td></td> </tr> <tr> <td><b>INSURER F:</b></td> <td></td> </tr> </tbody> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	<b>INSURER A:</b> Old Republic Insurance Company	24147	<b>INSURER B:</b> American Guarantee & Liability Ins Co	26247	<b>INSURER C:</b> Travelers Property Casualty Company of America	25674	<b>INSURER D:</b>		<b>INSURER E:</b>		<b>INSURER F:</b>	
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<b>INSURED</b> UNITEDHEALTH GROUP 9900 BREN ROAD EAST MN008-W345 MINNETONKA, MN 55343															

**COVERAGES** **CERTIFICATE NUMBER:** CHI-004418127-11 **REVISION NUMBER:** 11

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS																					
A	<input checked="" type="checkbox"/> <b>GENERAL LIABILITY</b> <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC			MWZY302189	05/01/2014	05/01/2016	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>EACH OCCURRENCE</td><td style="text-align: right;">\$</td><td style="text-align: right;">1,000,000</td></tr> <tr><td>DAMAGE TO RENTED PREMISES (Ea occurrence)</td><td style="text-align: right;">\$</td><td style="text-align: right;">1,000,000</td></tr> <tr><td>MED EXP (Any one person)</td><td style="text-align: right;">\$</td><td style="text-align: right;">2,500</td></tr> <tr><td>PERSONAL &amp; ADV INJURY</td><td style="text-align: right;">\$</td><td style="text-align: right;">1,000,000</td></tr> <tr><td>GENERAL AGGREGATE</td><td style="text-align: right;">\$</td><td style="text-align: right;">3,000,000</td></tr> <tr><td>PRODUCTS - COMP/OP AGG</td><td style="text-align: right;">\$</td><td style="text-align: right;">2,000,000</td></tr> <tr><td></td><td style="text-align: right;">\$</td><td></td></tr> </table>	EACH OCCURRENCE	\$	1,000,000	DAMAGE TO RENTED PREMISES (Ea occurrence)	\$	1,000,000	MED EXP (Any one person)	\$	2,500	PERSONAL & ADV INJURY	\$	1,000,000	GENERAL AGGREGATE	\$	3,000,000	PRODUCTS - COMP/OP AGG	\$	2,000,000		\$	
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B	<input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$			AUC596527907	05/01/2015	05/01/2016	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>EACH OCCURRENCE</td><td style="text-align: right;">\$</td><td style="text-align: right;">5,000,000</td></tr> <tr><td>AGGREGATE</td><td style="text-align: right;">\$</td><td style="text-align: right;">5,000,000</td></tr> <tr><td></td><td style="text-align: right;">\$</td><td></td></tr> </table>	EACH OCCURRENCE	\$	5,000,000	AGGREGATE	\$	5,000,000		\$													
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AGGREGATE	\$	5,000,000																										
	\$																											
C	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> N	N/A	HC2JUB472M475515 (AOS) HRJUB472M476715 (MA & WI) HWXJUB472M477915 (XWC OH)	05/01/2015	05/01/2016	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><input checked="" type="checkbox"/> WC STATUTORY LIMITS</td> <td><input type="checkbox"/> OTHER</td> <td></td> </tr> <tr><td>E.L. EACH ACCIDENT</td><td style="text-align: right;">\$</td><td style="text-align: right;">1,000,000</td></tr> <tr><td>E.L. DISEASE - EA EMPLOYEE</td><td style="text-align: right;">\$</td><td style="text-align: right;">1,000,000</td></tr> <tr><td>E.L. DISEASE - POLICY LIMIT</td><td style="text-align: right;">\$</td><td style="text-align: right;">1,000,000</td></tr> </table>	<input checked="" type="checkbox"/> WC STATUTORY LIMITS	<input type="checkbox"/> OTHER		E.L. EACH ACCIDENT	\$	1,000,000	E.L. DISEASE - EA EMPLOYEE	\$	1,000,000	E.L. DISEASE - POLICY LIMIT	\$	1,000,000									
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**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)**

THE GENERAL LIABILITY POLICY INCLUDES A BLANKET ADDITIONAL INSURED ENDORSEMENT FOR PERSONS OR ORGANIZATIONS WHERE UNITEDHEALTH GROUP IS OBLIGATED TO PROVIDE SUCH STATUS BY WRITTEN CONTRACT OR AGREEMENT, ONLY TO THE MINIMUM EXTENT REQUIRED AND SUBJECT TO POLICY TERMS AND CONDITIONS.

<b>CERTIFICATE HOLDER</b>  UNITEDHEALTH GROUP 9900 BREN ROAD EAST MN008-W345 MINNETONKA, MN 55343	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  AUTHORIZED REPRESENTATIVE of Marsh USA Inc.  Manashi Mukherjee <i>Manashi Mukherjee</i>
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# EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY)

02/27/2015

THIS EVIDENCE OF PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND, OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

PRODUCER NAME, CONTACT PERSON AND ADDRESS: Willis of Minnesota, Inc. c/o 26 Century Blvd. P. O. Box 305191 Nashville, TN 37230-5191	PHONE (A/C, No, Ext): 877-945-7378	COMPANY NAME AND ADDRESS Factory Mutual Insurance Company 300 S. Norwest Hwy Park Ridge, IL 60068	NAIC NO: 21482-002
FAX (A/C, No): 888-467-2378	E-MAIL ADDRESS: certificates@willis.com	IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	
CODE: AGENCY CUSTOMER ID #:	SUB CODE:	POLICY TYPE Commercial Property	
NAMED INSURED AND ADDRESS EVIDENCE OF INSURANCE FOR UnitedHealth Group 9900 Bren Road East Minneapolis, MN 55440-1459	LOAN NUMBER	POLICY NUMBER FS393	
ADDITIONAL NAMED INSURED(S)	EFFECTIVE DATE 03/01/2015	EXPIRATION DATE 03/01/2016	<input type="checkbox"/> CONTINUED UNTIL TERMINATED IF CHECKED
		THIS REPLACES PRIOR EVIDENCE DATED:	

PROPERTY INFORMATION (Use REMARKS on page 2, if more space is required)  BUILDING OR  BUSINESS PERSONAL PROPERTY

LOCATION/DESCRIPTION
----------------------

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION	PERILS INSURED	BASIC	BROAD	SPECIAL
COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: \$	100,000,000			DED: \$100,000
		YES NO N/A		
<input checked="" type="checkbox"/> BUSINESS INCOME <input checked="" type="checkbox"/> RENTAL VALUE		x		If YES, LIMIT: <b>Included</b> <input checked="" type="checkbox"/> Actual Loss Sustained; # of months <sup>12</sup>
BLANKET COVERAGE		x		If YES, indicate value(s) reported on property identified above: <b>Included</b>
TERRORISM COVERAGE		x		Attach Disclosure Notice / DEC
IS THERE A TERRORISM-SPECIFIC EXCLUSION?			x	
IS DOMESTIC TERRORISM EXCLUDED?			x	
LIMITED FUNGUS COVERAGE		x		If YES, LIMIT: \$1,000,000 DED: \$100,000
FUNGUS EXCLUSION (If "YES", specify organization's form used)			x	
REPLACEMENT COST		x		
AGREED VALUE		x		
COINSURANCE			x	If YES, %
EQUIPMENT BREAKDOWN (If Applicable)		x		If YES, LIMIT: <b>Included</b> DED: \$100,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg		x		If YES, LIMIT: <b>Included</b> DED: \$100,000
- Demolition Costs		x		If YES, LIMIT: <b>Included</b> DED: \$100,000
- Incr. Cost of Construction		x		If YES, LIMIT: <b>Included</b> DED: \$100,000
EARTH MOVEMENT (If Applicable)		x		If YES, LIMIT: \$5,000,000 DED: 5% - \$250,000 MIN
FLOOD (If Applicable)		x		If YES, LIMIT: \$5,000,000 DED: \$500,000
WIND / HAIL INCL <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Subject to Different Provisions:			x	If YES, LIMIT: DED:
NAMED STORM INCL <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Subject to Different Provisions:		x		If YES, LIMIT: \$100,000,000 DED: 5% - \$100,000 MIN
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS		x		

### CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

### ADDITIONAL INTEREST

MORTGAGEE	CONTRACT OF SALE	LENDER SERVICING AGENT NAME AND ADDRESS
LENDERS LOSS PAYABLE		
NAME AND ADDRESS		
EVIDENCE OF INSURANCE		
:		
:		
		AUTHORIZED REPRESENTATIVE

## EXHIBIT C

### DENVER LOGO COLORS



The Denver logo is available in a horizontal layout, which is preferred, or a vertical layout. The color palette is comprised of five colors:



**PMS 1805**  
BRICK RED



**PMS 2925**  
SKY BLUE



**PMS 130**  
SUNSHINE  
GOLD



**PMS 268**  
MOUNTAIN  
PURPLE



**PANTONE**  
**PROCESS**  
**80% BLACK**

**REVERSE USAGE** A reverse version of the Denver logo has been developed to be used on black or other dark colors. A white border is used to separate the symbol from the background. The logotype and tagline are white instead of black to increase legibility. When only one color is available, the black logo or one-color reverse artwork should be used. Additional details on the appropriate use of the Denver logo can be found in the [Denver brand center](#).