UNITED HEALTHCARE INSURANCE COMPANY AMENDMENT

This Amendment is part of the respective Group Policies governing the following plans: *United Healthcare Navigate Plan 1GK*, and the *United Healthcare Choice Plan C8E*. Certain capitalized words have defined meanings as defined in the Certificate of Coverage for each plan ("**Certificate**") in *Section 9: Defined Terms*.

The Following is added to the Group Policy:

AGREEMENT TO PURCHASE

The following documents are attached as exhibits hereto:

Navigate Plan: Group Policy document for the *United Healthcare Navigate Plan 1GK* (attached as **Exhibit A**), Certificate of Coverage for the *United Healthcare Navigate Plan 1GK* (attached as **Exhibit B**);

Choice Plan: Group Policy document for the *United Healthcare Choice Plan C8E* (attached as **Exhibit C**), Certificate of Coverage for the *United Healthcare Choice Plan C8E* (attached as **Exhibit D**).

The above documents, including any amendments or addendums thereto, collectively constitute the Entire Agreement to Purchase ("**Agreement**") between United Healthcare ("**United**"), and the Enrolling Group (hereinafter referred to as either the "**Enrolling Group**" or the "**City**") named below for the provision of health care benefits to eligible persons electing to enroll hereunder as Members.

1. **ENROLLING GROUP.**
   (a) The name, address and group number of the Enrolling Group are as follows:

   City and County of Denver
   ATTN: Office of Human Resources
   201 West Colfax Ave., Dept. 412
   Denver, CO 80202
   Group number: 717340

   The City herby delegates to **Nita Henry, as Executive Director of the Office of Human Resources**, or her designee, to sign any document necessary to effectuate insurance coverage under this Agreement.

2. **EFFECTIVE DATE AND TERM.** The Agreement and the underlying insurance policies shall be effective as of 12:01 a.m., Denver time on January 1, 2013, ("**Effective Date**") and shall terminate at 11:59 p.m., on December 31, 2013.

3. **MONTHLY PREMIUMS.**

Only Covered Persons for whom United has received the appropriate Premium rates listed on the Schedule of Premium Rates are entitled to coverage under this Agreement and the attached Exhibits, and then only for the period for which United has received appropriate payment.

4. **OPEN ENROLLMENT PROVISIONS.** The Enrolling Group's Open Enrollment Period shall end at least thirty (30) days prior to the new enrollment period with all required enrollment documentation received by United Member Services.

Subscribers must either complete and sign an approved enrollment application or enroll through the City's online enrollment process in order to be eligible for enrollment with United.

5. **TERMINATION.** This Agreement may be terminated by the Enrolling Group on the anniversary of the Effective Date, upon thirty (30) days' advance written notice to United or under the terms of the policies as referenced above.

6. **DISPUTE RESOLUTION PROCESS**. Neither the Group nor United may initiate litigation to resolve any dispute without first attempting to resolve the dispute with the other party. The Parties agree to meet in a good faith and participate in a collaborative effort to resolve the dispute. The Parties further agree that the terms of section 6.2 entitled '*Dispute Resolution*' of the applicable Group Policy apply to this provision.

7. **GOVERNING LAW AND VENUE; DAMAGES LIMITATION.** The Agreement shall be governed and construed in accordance with laws of the State of Colorado. Any action or legal proceeding commenced or maintained by Enrolling Group or any employee or United Covered Person relating to or arising out of this Agreement or the Exhibits attached hereto must be exclusively venued in a court of competent jurisdiction located in the City and County of Denver, Colorado. The Enrolling Group, for itself and on behalf of its employees and their dependents who are covered individuals under this Agreement, agrees and consents to such venue and the subject matter and personal jurisdiction of such court located within Denver, Colorado. No court is empowered to award punitive damages or damages in excess of compensatory damages.

8. **AMENDMENT.** This Agreement may be amended by mutual consent of United and the Enrolling Group, and in accordance with the terms in section 6.4 (entitled "*Amendments and Alterations*") of the respective Group Policy.

9. <u>INSURANCE</u>:

(a) <u>General Conditions:</u> United 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. United 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 required 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. Such notice 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, United 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. United 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 United. United 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: United may not commence services or work relating to the Agreement prior to placement of coverage. United certifies that they have provided an ACORD Certificate of Liability Insurance that complies with all the stated insurance requirements of this Agreement (**Exhibit E**, ACORD Certificate of Liability Insurance). 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 United'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, United's insurer shall waive subrogation rights against the City.

(d) Subcontractors and Subconsultants: All subcontractors and subconsultants (including independent contractors, suppliers or other entities providing goods or services required by this Agreement) shall be subject to all of the requirements herein and shall procure and maintain the same coverages required of the United. United shall include all such subcontractors as additional insured under its policies (with the exception of Workers' Compensation) or shall ensure that all such subcontractors and subconsultants maintain the required coverages. United agrees to provide proof of insurance for all such subcontractors and subconsultants upon request by the City.

(e) Workers' Compensation/Employer's Liability Insurance: United 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. United expressly represents to the City, as a material representation upon which the City is relying in entering into this Agreement, that none of the United'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 United executes this Agreement.

(f) Commercial General Liability: United 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.

(g) Business Automobile Liability: United 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

(h) Professional Liability (Errors & Omissions): United shall maintain limits of

$1,000,000 per claim and $1,000,000 policy aggregate limit.

(i) Technology Errors & Omissions including Cyber Liability: United shall maintain Technology Errors and Omissions insurance including cyber liability, network security, privacy liability and product failure coverage with limits of $1,000,000 per occurrence and $1,000,000 policy aggregate.

10. **INDEMNIFICATION.** To the fullest extent permitted by law, United 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 United or United'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.

(a) United'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 United is not named as a Defendant.

(b) United 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.

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

(d) This defense and indemnification obligation shall survive the expiration or termination of this Agreement.

11. **AGENCY.** The City is not United's agent or representative, and the City shall not be liable for any acts or omissions of United's officers, agents or employees.

12. **APPROPRIATION.** Notwithstanding any other term or condition or covenant of this Agreement, it is understood and agreed that any payment obligation of the City hereunder, whether direct or contingent, shall extend only to funds appropriated by the Denver City Council for the purpose of this agreement in the year in which the obligation is incurred, encumbered for the purpose of this agreement and paid into the Treasury of the City. United acknowledges that (i) the City does not by this Agreement irrevocably pledge present cash reserves for payments in future fiscal years, and (ii) this agreement is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

The maximum contract amount for the City's obligation for all policies listed herein under this Agreement during the Term of January 1, 2013 through and including December 31, 2013, shall not exceed Forty One Million Dollars ($41,000,000.00), without amendment of this Agreement ("**Maximum Contract Amount**").

13. **CONFIRMATOIN OF LAWFUL EMPLOYMENT STATUS UNDER THIS 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 United certifies that:

(1) At the time of its execution of this Agreement, it does not knowingly employ or contract with anyone who is unlawfully employed pursuant to the Certification Statute ("**Unlawful Worker**") 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. United also agrees and represents that:

(1) It shall not knowingly employ or contract with an Unlawful Worker to perform work under this Agreement

(2) It shall not enter into a contract with a sub-consultant or subcontractor that fails to certify to the Consultant that it shall not knowingly employ or contract with an Unlawful Worker to perform work under this 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 this Agreement, and that otherwise requires the Consultant 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 sub-consultant or subcontractor performing work under this Agreement knowingly employs or contracts with an Unlawful Worker, it will notify such sub-consultant or subcontractor and the City within three (3) days. The Consultant will also then terminate such sub-consultant or subcontractor if within three (3) days after such notice the sub-consultant or subcontractor does not stop employing or contracting with the Unlawful Worker, unless during such three-day period the sub-consultant or subcontractor provides information to establish that the sub-consultant or subcontractor has not knowingly employed or contracted with an Unlawful Worker.

(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.

United is liable for any violations as provided in the Certification Ordinance. If United violates any provision of this section or the Certification Ordinance, the City may terminate this Agreement for a breach of this Agreement.

14. **CONFIDENTIAL INFORMATION.** United shall not at any time or in any manner, either directly or indirectly, divulge, disclose or communicate to any person, firm or corporation in any manner whatsoever any City information which is not subject to public disclosure, including without limitation the Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder as amended ("**HIPAA**"), the trade secrets of businesses or entities doing business with the City, the data contained in any of the data bases of the City, and other privileged or confidential information. This provision shall not prevent United from using information as needed for the normal operation of a health maintenance organization, including but not limited to, quality assurance reviews, utilization management, claims processing, and any reporting or auditing required by the Colorado Division of Insurance or any other governmental agencies having jurisdiction over United. This obligation shall survive the termination of this Agreement. United shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. Further United shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is given.

15. **NO DISCRIMINATION IN EMPLOYMENT.** In connection with the performance of work under this Agreement, United agrees not to refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, marital status, or physical or mental disability; and further agrees to insert the foregoing provision in all subcontracts hereunder.

16. **COLORADO GOVERNMENTAL IMMUNITY ACT.** United understands and agrees that the City is relying on, and has not waived, the monetary limitations (presently $150,000 per person, $600,000 per occurrence) and all other rights, immunities and protection provided by the Colorado Governmental Immunity Act, C.R.S. §24-10-101 *et seq*.

17. **AUDIT.** United agrees that it will keep and preserve for at least six (6) years all directly pertinent books, documents, papers and records of United involving transactions related to this Agreement, and that it will make available to the City's authorized representatives (approved by United and paid for by the City) reasonable access during reasonable hours to examine and/or copy such books and records necessary for the planning, administration and financial functions of the City's employee health benefits plan, subject to applicable state and federal confidentiality laws, and United's internal procedures regarding audits. United retains full discretion with respect to granting any request for a claims audit.

18. **VALIDITY.** The unenforceability or invalidity of any part of this Agreement shall not affect the enforceability and validity of the other terms and conditions of this Agreement.

19. **COUNTERPARTS.** This Agreement may be executed in two or more counterparts, each of which shall constitute an original but all of which shall constitute one and the same document.

{THE REMAINDER OF THIS PAGE IS 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-201310004-00

Contractor Name: United Health Care

By: Elizabeth Soberg Prokacki

Name: Elizabeth Soberg Prokacki
(please print)

Title: CEO, Rocky Mountain States
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

UNITED HEALTHCARE INSURANCE COMPANY AGREEMENT
EXHIBIT A

Policy document for the *United Healthcare Navigate Plan 1GK*

UnitedHealthcare Insurance Company

Group Policy

For

City and County of Denver

Enrolling Group Number: 717340

Policy Effective Date: January 1, 2013

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

800-357-1371

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

800-357-1371

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.

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, 2013 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 75% 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 06103-3408

   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 1GK.

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, 2013.

   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, 2013 is shown below:

Coverage Classification	**Monthly Premium**
Employee Only	$435.16
Employee plus Spouse	$957.37
Employee plus Child(ren)	$870.34
Employee plus Family	$1,392.52

   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 Other Employees enrolled in United Healthcare Navigate Plan 1GK.

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, 2013.

   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, 2013 is shown below:

Coverage Classification	**Monthly Premium**
Employee Only	$576.58
Employee plus Spouse	$1,268.50
Employee plus Child(ren)	$1,153.20
Employee plus Family	$1,845.40

   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*.

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.

UNITED HEALTHCARE INSURANCE COMPANY AGREEMENT
EXHIBIT B

Certificate of Coverage for the *United Healthcare Navigate Plan 1GK*

UnitedHealthcare Navigate

UnitedHealthcare Insurance Company

Certificate of Coverage

For

City and County of Denver

Enrolling Group Number: 717340

Effective Date: January 1, 2013

Offered and Underwritten by

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

800-357-1371

Table of Contents

Amendments, Riders and Notices (As Applicable)

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 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**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. 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. 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. 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 *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per	$500 per Covered Person, not to exceed $1,500 for all Covered Persons in a family.

Payment Term And Description	Amounts
Occurrence Deductible.	
Per Occurrence Deductible	
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. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. 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: • Any charges for non-Covered Health Services. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum. • Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider.*	$2,500 per Covered Person, not to exceed $5,000 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.
Copayment	
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. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Payment Term And Description	Amounts
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* 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?
1. Ambulance Services			
Prior Authorization Recommendation 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.			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air Ambulance: 80%	Yes	Yes
2. Congenital Heart Disease Surgeries			
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 *Schedule of Benefits*.	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
3. Dental Services - Accident Only			
Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.	80%	Yes	Yes
4. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	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		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*.	in this *Schedule of Benefits*. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider.*		
5. Durable Medical Equipment			
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. Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are included in the annual limits stated above. You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80%	Yes	Yes
6. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within 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	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	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?
provided.	apply instead.		
7. Hearing Aids for Adults			
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.	80%	Yes	Yes
8. Hearing Aids for Minor Children			
	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 *Schedule of Benefits*.		
9. Home Health Care			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80%	Yes	Yes
10. Hospice Care			
Bereavement support services are limited to $1,150 during the 12-month period following the Covered Person's death.	80%	Yes	Yes
11. Hospital - Inpatient Stay			
	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
12. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient: **X-Ray and Other Diagnostic Testing - Outpatient:**	80% 80%	Yes Yes	Yes Yes

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
13. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100% after you pay a Copayment of $150 per service	No	No
14. Mental Health Services			
	Inpatient ***Non-Biologically Based Mental Illness or Mental Disorders*** 80% ***Biologically Based Mental Illness or Mental Disorders*** 80% *Outpatient* ***Non-Biologically Based Mental Illness or Mental Disorders*** 100% after you pay a Copayment of $50 per visit ***Biologically Based Mental Illness or Mental Disorders*** 100% after you pay a Copayment of $50 per visit	 Yes Yes No No	 Yes Yes No No
15. Neurobiological Disorders - Autism Spectrum Disorder Services			
	Inpatient 80% *Outpatient* 100% after you pay a	 Yes No	 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?
	Copayment of $50 per visit		
16. Ostomy Supplies			
Limited to $2,500 per year.	80%	Yes	Yes
17. Pharmaceutical Products - Outpatient			
	80%	Yes	Yes
18. Physician Fees for Surgical and Medical Services			
	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
19. Physician's Office Services - Sickness and Injury			
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: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products -*	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 100% after you pay a Copayment of $50 per visit 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?
Outpatient. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	Primary Physician		
20. Pregnancy - Maternity Services			
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.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
21. Preventive Care Services			
Physician office services	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
Lab, X-ray or other preventive tests	100% for services provided by your Primary Physician or	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?
Additional Preventive Care Services	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 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
22. Prosthetic Devices			
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 *Women's Health and Cancer Rights Act of 1998* and for prosthetic arms, legs, feet and hands.	80%	Yes	Yes
23. Reconstructive Procedures			
	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 *Schedule of Benefits*.		
24. Rehabilitation Services - Outpatient Therapy and			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Manipulative Treatment			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	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 Copayment of $25 per visit for all other rehabilitation services	No	No
25. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	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
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to 60 days per year.	80%	Yes	Yes
27. Substance Use Disorder			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Services			
	Inpatient 80% *Outpatient* 100% after you pay a Copayment of $50 per visit	 Yes No	 Yes No
28. Surgery - Outpatient			
	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
29. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
30. Transplantation Services			
Prior Authorization Recommendation 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 *Schedule of Benefits*.		
31. Urgent Care Center Services			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health	100% after you pay a Copayment of $75 per visit	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?
Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.			
32. Vision Examinations			
Limited to 1 exam every 2 years.	100% after you pay a Copayment of $25 per visit	No	No

Additional Benefits Required By Colorado Law

33. Autism Spectrum Disorders	
Prior Authorization Recommendation 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.	
	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 *Schedule of Benefits*.

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
34. Cleft Lip and Cleft Palate Treatment			
Prior Authorization Recommendation 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.			
	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 *Schedule of Benefits*.		
35. Clinical Trials			
Prior Authorization Recommendation 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.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* 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.)	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 *Schedule of Benefits*.		
36. Colorectal Cancer Screening			
	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 *Schedule of Benefits*. The screening for the early detection of colorectal cancer and adenomatous polyps is not subject to any deductibles.		
37. Hospitalization and General Anesthesia for Dental Procedures for Children			
Prior Authorization Recommendation			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
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 *Schedule of Benefits*.		
38. Phenylketonuria (PKU) Testing and Treatment			
Prior Authorization Recommendation 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 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 *Schedule of Benefits.*		
39. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)			
Prior Authorization Recommendation 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	No	No
40. Telemedicine			
	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 *Schedule of Benefits*.		

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 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 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 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

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

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

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

Benefits are available for repairs and replacement, except that:

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

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 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*.)

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

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

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

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 or in a Physician's office.

Benefits under this section include:

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

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 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 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*.

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

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 except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
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). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

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

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 for Total Disability

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

- The Total Disability ends.
- Three months from the date coverage would have ended when the entire Policy was terminated.

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.

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

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 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 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 phoebia, 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 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.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

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

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence

available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

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

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).

Standard Section Names as required by Colorado Regulation 4-2-34	**UnitedHealthcare Current Section Names**
Schedule of Benefits (Who Pays What)	Schedule of Benefits
Title Page (Cover Page)	Title Page (Cover Page)
Contact Us	• Certificate of Coverage Cover Page • Certificate of Coverage - *Introduction to Your Certificate: Don't Hesitate to Contact Us*
Table of Contents	Certificate of Coverage: *Table of Contents*
Eligibility	Certificate of Coverage: *Section 3: When Coverage Begins*
How to Access Your Services and Obtain Approval of Benefits	Schedule of Benefits: *Accessing Benefits*
Benefits/Coverage (What is Covered)	Certificate of Coverage - *Section 1: Covered Health Services*
Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)	Certificate of Coverage - *Section 2: Exclusions and Limitations*
Member Payment Responsibility	Schedule of Benefits - *Benefits*
Claims Procedures (How to File a Claim)	Certificate of Coverage - *Section 5: How to File a Claim*
General Policy Provisions	Group Policy - *Article 6: General Provisions*
Termination/Nonrenewal/Continuation	Certificate of Coverage - *Section 4: When Coverage Ends*
Appeals and Complaints	Certificate of Coverage - *Section 6: Questions, Complaints and Appeals*
Information on Policy and Rate Changes	Group Policy - *Article 3: Premium Rates and Policy Charge*
Definitions	Certificate of Coverage - *Section 9: Defined Terms*

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 limited to a maximum of $1,400 during the 12-month period following death)
- 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			
Bereavement support services are limited to $1,400 during the 12-month period following the Covered Person's death)	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), 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).

4. 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

Questions, Complaints and Appeals Amendment

UnitedHealthcare Insurance Company

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

As described in this Amendment, the Policy is modified by replacing *Section 6: Questions, Complaints and Appeals* of the *Certificate of Coverage* with the provision below.

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 benefit 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 no later than 30 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 have the right to request a voluntary second level appeal. Your voluntary 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 7 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. If you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your voluntary 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 7 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.

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.

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

Independent External Review Program

If, after the completion or exhaustion of the first level appeal or the voluntary second level 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 one of the above conditions is met, you or your designated representative may request an independent external review of adverse benefit determinations 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).

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 determinations are based on Benefit exclusions or defined Benefit limits 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 first level appeal determination.
- Within 60 calendar days after you receive notification of our voluntary second level appeal determination.
- At the same 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.

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 regarding your first level appeal or within 60 days of the date you received our adverse determination concerning your voluntary second level appeal.

1. Within two working 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 working days of receipt of the independent external review request.
3. Within one working 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 working 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 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 working day for concurrent and prospective reviews of pre-service requests for Benefits.

- Within 5 working days for retrospective reviews of post-service claims.

We will provide written notice of the approval to you and your designated representative within one working 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.

1. Within one working 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 working day of receipt of the expedited independent external review request.

3. Within one working 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 written 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.

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 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 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 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 or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- Copayments for Prescription Drug Products, including Specialty Prescription Drug Products.
- Coinsurance for Prescription Drug Products, including Specialty Prescription Drug Products.
- 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
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Copayment and Coinsurance*** 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. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. **Prescription Drug Products Prescribed by a Specialist Physician:** 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 www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. **NOTE:** The tier status of a Prescription	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Payment Term And Description	Amounts
Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. 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. 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. 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. For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge. Benefits for oral chemotherapeutic agents are not subject to payment of the Annual Drug Deductible.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. 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. 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. For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of

Description and Supply Limits	Benefit (The Amount We Pay)
consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	$60.00 per Prescription Order or Refill. For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • 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 *Specialty Prescription Drug Products.* 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.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For up to a 90-day supply, we pay: 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. 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. 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. For oral chemotherapeutic agents on any Tier, 100% of the Prescription Drug Charge.

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 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 or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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

Section 2: Exclusions

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

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

1. 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. 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 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 and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

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

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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

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.

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

IMPORTANT NOTICE: If you have a dependent child whose coverage ended or who was denied coverage (or was not eligible for coverage) because dependent coverage of children was not available up to age 26, you may have the right to enroll that dependent under a special dependent child enrollment period. This right applies as of the first day of the first plan year beginning on or after September 23, 2010 and your employer (or enrolling group) must provide you with at least a 30 day enrollment period. If you are adding a dependent child during this special enrollment period and have a choice of coverage options under the plan, you will be allowed to change options. This child special open enrollment may coincide with your annual open enrollment, if you have one. Please contact your employer or group plan administrator for more information.

IMPORTANT NOTICE: If coverage or benefits for you or a dependent ended due to reaching a lifetime limit, be advised that a lifetime limit on the dollar value of benefits no longer applies. If you are covered under the plan, you are once again eligible for benefits. Additionally, if you are not enrolled in the plan, but are still eligible for coverage, then you will have a 30 day opportunity to request enrollment. This 30 day enrollment opportunity will begin no later than the first day of the first plan year beginning on or after September 23, 2010. This 30 day enrollment period may coincide with your annual open enrollment, if you have one. Please contact your employer or group health plan administrator for more information.

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; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; 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.

- Any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to covered persons under the age of 19.

- 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*.

  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.

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. 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. 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.

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

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, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical 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. 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. 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.

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.

We* 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 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 a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on our website www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

**For purposes of this Notice of Privacy Practices, "we" or "us" refers 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; American Medical Security Life Insurance Company; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Evercare of New Mexico, Inc.; Evercare of Texas, LLC; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, 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; Physicians Health Choice of Texas, LLC; Sierra Health & Life Insurance Co., Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Family Health Plan of Pennsylvania, Inc.; Unison Health Plan of Delaware, Inc.; Unison Health Plan of Pennsylvania, Inc.; Unison Health Plan of Tennessee, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, Inc.; *UnitedHealthcare Community Plan of Ohio, Inc.*; *UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Great Lakes Health Plan, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, 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 South Carolina, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.*

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 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.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **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.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

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:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;

- Sexually transmitted diseases and reproductive health information; and
- 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 summary of federal and state laws on use and disclosure of certain types of medical information.

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. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at anytime 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. We will accept verbal requests to receive confidential communications, but 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 health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend** information we maintain about you 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) prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) 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 at our website, www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on the back of your ID card or you may contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.
- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for 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.

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.

We** are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means 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.
- 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.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the **Health Plan Notices of Privacy Practices**, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; National Pacific Dental, Inc.; Nevada Pacific Dental; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; 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.*

Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with state and federal standards to guard your personal financial information. We conduct regular audits to help ensure appropriate and secure handling and processing of our enrollees' information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free phone number on the back of your ID card or you may contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.

UnitedHealth Group

Health Plan Notice of Privacy Practices: Federal and State Amendments

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.
- Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	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 health information.	NV
We are not allowed to use health information for certain purposes.	CA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	MO, NJ, SD
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV

Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, HI, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, GA, HI, KY, IL, IN, IA, LA, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, HI, 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
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WA, WI, WV, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, HI, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

UNITED HEALTHCARE INSURANCE COMPANY AGREEMENT
EXHIBIT C

Group Policy document for the *United Healthcare Choice Plan C8E*

UnitedHealthcare Insurance Company

Group Policy

For

City and County of Denver

Enrolling Group Number: 717340

Policy Effective Date: January 1, 2013

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

800-357-1371

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 provided us with false information 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 we received the false information, 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 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, if 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 thirty (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.

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 of Coverage(s)* and *Schedule(s) of Benefits* online at 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, 2013 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.

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 75% 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 06103-3408

   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 Choice Plan C8E.

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

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, 2013.

   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.

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, 2013 is shown below:

Coverage Classification	**Monthly Premium**
Employee Only	$531.55
Employee plus Spouse	$1,169.43
Employee plus Child(ren)	$1,063.12
Employee plus Family	$1,700.96

   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 Other Employees enrolled in United Healthcare Choice Plan C8E.

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

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, 2013.

   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.

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, 2013 is shown below:

Coverage Classification	**Monthly Premium**
Employee Only	$704.57
Employee plus Spouse	$1,550.08
Employee plus Child(ren)	$1,409.19
Employee plus Family	$2,255.03

   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.

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.

UNITED HEALTHCARE INSURANCE COMPANY AGREEMENT
EXHIBIT D

Certificate of Coverage for the *United Healthcare Choice Plan C8E*

UnitedHealthcare Choice

UnitedHealthcare Insurance Company

Certificate of Coverage

For

City and County of Denver

Enrolling Group Number: 717340

Effective Date: January 1, 2013

Offered and Underwritten by

UnitedHealthcare Insurance Company

Table of Contents

Amendments, Riders and Notices (As Applicable)

Standard Section Names
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Amendment
Patient Protection and Affordable Care Act (PPACA) Amendment
Preventive Care Services And Other Mandates Amendment
Off Label Drugs Amendment
Home Health Care and Hospice Care Amendment
2010 Certificate of Coverage Amendment
Domestic Partner Amendment
Questions, Complaints and Appeals Amendment
Health Resources and Services Administration (HRSA) Amendment
Outpatient Prescription Drug Rider
Patient Protection and Affordable Care Act (PPACA) Preventive Care Medications Addendum
Important Notices under the Patient Protection and Affordable Care Act (PPACA)
Changes in Federal Law that Impact Benefits
Patient Protection and Affordable Care Act (PPACA)
Some Important Information about Appeal and External Review Rights under PPACA

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 anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

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

Pre-service Benefit Confirmation

We recommend you notify before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. There are some Benefits, however, for which you are responsible for notifying us. Services for which we recommend pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services for which we recommend pre-service notification:

- Ambulance - non-emergent air and ground.
- Children's Dental Anesthesia.
- Cleft Lip and Cleft Palate Treatment.
- Clinical trials.
- Phenylketonuria (PKU) Testing and Treatment.
- Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities).
- Transplants.

As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness. For Network Benefits, after your Network provider contacts us for pre-service Benefit confirmation, we will identify the Benefit level available to you.

The process and procedures used to define clinical protocols and cost-effectiveness of a health service and a listing of services subject to these provisions (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

If you request a coverage determination at the time notice 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.

Mental Health Services and Substance Use Disorder Services

Mental Health Services (including psychiatric services for Autism Spectrum Disorders and Substance Use Disorder Services are not subject to the pre-service notification recommendations described above. Instead, you should obtain prior authorization from the Mental Health/Substance Use Disorder Designee before you receive Covered Health Services. You can contact the Mental Health/Substance Use Disorder Designee at the telephone number on your ID card.

To receive the highest level of Benefits and to avoid incurring the penalties described in this *Schedule of Benefits* table within each Covered Health Service category, you should call the Mental Health/Substance Use Disorder Designee before obtaining Mental Health Services or Substance Use Disorder Services. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. When you call the Mental Health/Substance Use Disorder Designee as recommended, you will be given the names of Network providers who are experienced in addressing your specific problems or concerns.

The Mental Health/Substance Use Disorder Designee performs utilization review to determine whether the requested service is a Covered Health Service. The Mental Health/Substance Use Disorder Designee does not make treatment decisions about the kind of behavioral health care you should or should not receive. You and your provider must make those treatment decisions.

Care Coordination[SM]

When we are notified as recommended, we will work with you to implement the Care Coordination[SM] 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 pre-service notification recommendation does 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 notify us 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
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive 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. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	No Annual Deductible.
Out-of-Pocket Maximum	
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. 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 *Schedule of Benefits* table. 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: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not notify us as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum. • Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider.*	$3,000 per Covered Person, not to exceed $6,000 for all Covered Persons in a family.
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the	No Maximum Policy Benefit.

Payment Term And Description	Amounts
entire period of time you are enrolled under the Policy.	
Copayment	
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. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* 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?
1. Ambulance Services			
Pre-service Notification Recommendation In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you should notify us as soon as possible prior to transport so that we can determine whether the service meets the definition of a Covered Health Service.			
Emergency Ambulance	*Ground Ambulance:* 100%	No	No
	Air Ambulance: 100%	No	No
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* 100%	No	No
	Air Ambulance: 100%	No	No
2. Congenital Heart Disease Surgeries			
Network Benefits under this section include only 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 *Schedule of Benefits*.	100% after you pay a Copayment of $500 per day to a maximum Copayment of $2,500 per Inpatient Stay	Yes	No
3. Dental Services - Accident Only			
Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.	100%	No	No
4. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	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 *Schedule of Benefits*.		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment.*	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider.*		
5. Durable Medical Equipment			
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. Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are included in the annual limits stated above. 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
6. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you should 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
7. Hearing Aids for Adults			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Limited to $2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every three years.	100%	No	No
8. Hearing Aids for Minor Children			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits.*		
9. Home Health Care			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	100%	No	No
10. Hospice Care			
Bereavement support services are limited to $1,150 during the 12-month period following the Covered Person's death.	100%	No	No
11. Hospital - Inpatient Stay			
	100% after you pay a Copayment of $500 per day to a maximum Copayment of $2,500 per Inpatient Stay	Yes	No
12. Lab, X-Ray and Diagnostics - Outpatient			
	100%	No	No
13. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	100% after you pay a Copayment of $100 per service	No	No
14. Mental Health Services			
Prior Authorization Recommendation			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
You should obtain prior authorization through the Mental Health/Substance Use Disorder Designee in order to receive Benefits so that we can determine whether the service meets the definition of a Covered Health Service. **Pre-service Notification Recommendation** For Biologically Based Mental Illnesses or Mental Disorders, you should notify the Mental Health/Substance Abuse Designee five business days before admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions) 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 for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury*, and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
15. Neurobiological Disorders - Autism Spectrum Disorder Services			
Prior Authorization Recommendation You should obtain prior authorization through the Mental Health/Substance Use Disorder Designee 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 for outpatient *Neurobiological Services - Autism Spectrum Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury*, and Benefits for inpatient/intermediate *Neurobiological Services - Autism Spectrum Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this Schedule of Benefits.		
16. Ostomy Supplies			
Limited to $2,500 per year.	100%	No	No
17. Pharmaceutical Products - Outpatient			
	100%	No	No
18. Physician Fees for Surgical and Medical Services			
	100%	No	No
19. Physician's Office Services - Sickness and Injury			
In addition to the Copayment stated in	100% after you pay a	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?
this section, the Copayments/Coinsurance for the following services apply when the Covered Health Service is performed as an Emergency Health Service: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	Copayment of $35 per visit for a Primary Physician office visit or $60 per visit for a Specialist Physician office visit		
20. Pregnancy - Maternity Services			
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.			
	Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
21. Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
22. Prosthetic Devices			
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	100%	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?
continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.* Once this limit is reached, Benefits continue to be available for prosthetic arms, legs, feet and hands.			
23. Reconstructive Procedures			
	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 *Schedule of Benefits*.		
24. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of Manipulative Treatment. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy.	100% after you pay a Copayment of $60 per visit	No	No
25. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	100%	No	No
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to 60 days per year.	100% after you pay a Copayment of $500 per day to a maximum	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?
	Copayment of $2,500 per Inpatient Stay		
27. Substance Use Disorder			
Prior Authorization Recommendation You should obtain prior authorization through the Mental Health/Substance Use Disorder Designee 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 for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury*, and Benefits for inpatient/intermediate *Substance Use Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
28. Surgery - Outpatient			
	100% after you pay a Copayment of $350 per date of service	No	No
29. Therapeutic Treatments - Outpatient			
	100%	No	No
30. Transplantation Services			
Pre-service Notification Recommendation You should notify us 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.	100% after you pay a Copayment of $500 per day to a maximum Copayment of $2,500 per Inpatient Stay	Yes	No
31. Urgent Care Center Services			
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: • Major diagnostic and nuclear	100% after you pay a Copayment of $100 per visit	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?
medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.			

Additional Benefits Required By Colorado Law

32. Children's Dental Anesthesia	
Pre-service Notification Recommendation You should notify us 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.	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits.*
33. Cleft Lip and Cleft Palate Treatment	
Pre-service Notification Recommendation You should notify us 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.	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits.*
34. Clinical Trials	
Pre-Service Notification Recommendation You should notify us 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.	
Depending upon the Covered Health	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?
Services, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however, the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits.*		
35. Colorectal Cancer Screening			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits.*		
36. Phenylketonuria (PKU) Testing and Treatment			
Pre-Service Notification Recommendation Depending upon where the Covered Health Service is provided, notification requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits*. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits*.		
37. Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)			
Pre-Service Notification Recommendation You should notify us 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:	100% after you pay a	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?
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.	Copayment of $60 per visit		
38. Telemedicine			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health category in this *Schedule of Benefits*.		

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*.

If one or more alternative health services that meets the definition of Covered Health Service in the *Certificate of Coverage* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

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.

Provider Network

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

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

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

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

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

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

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 the *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.

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 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

Section 1: Covered Health Services

Benefits for Covered Health Services

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

- 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 and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

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 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, but are not limited to, 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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

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).
- 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 also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are

available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

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

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

Benefits are available for repairs and replacement, except that:

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

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.

Benefits under this section are not available for services to treat a condition that does not meet the definition 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 an alternative 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 that is provided on a per visit basis;
- 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 purposes 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 anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (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 include, but are not limited to:

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

Benefits under this section include:

- The facility charge and the charge for 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*.)

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

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

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 or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for 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*.)

14. Mental Health Services

Mental Health Services include those received on an inpatient or Intermediate Care 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 for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Mental Health Services*.

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. 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. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this *Certificate*.

Benefits include:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient/24-hour supervisory care.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family, therapeutic group, and provider-based case management services.
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family.
- Crisis intervention.
- Transitional 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 first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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.

Benefits under this section include allergy injections.

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

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

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. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

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

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

- 48 hours for the mother and newborn child following a normal vaginal delivery. 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, including clinical breast examinations and prostate examinations.
- Well baby and well child care.
- Immunizations. Immunization deficient children are not bound by "recommended ages."
- Hearing screening.
- Child Health Supervision Services.

Lab, X-ray or other preventive tests:

- Screening mammography, including:
    - A baseline mammogram for women 35 through 39 years of age.
    - A mammogram every two years for women 40 through 49 years of age.
    - An annual mammogram for women 50 years of age or older.
    - An annual mammogram for women 40 years of age or older who have risk factors, as determined by a Physician.

  Please refer to your Colorado Health Benefit Plan Description Form to determine whether your Benefits are provided on a calendar year or Policy year basis.
- 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.

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 or stolen 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 or stolen 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, are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.

- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural 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.

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, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for 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*.)

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 anesthesiologists, consulting Physicians, pathologists and radiologists. (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 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.

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 or Intermediate Care 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 or legal system.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Substance Use Disorder Services*.

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. 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, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for 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*.)

29. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to 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*.

Additional Benefits Required By Colorado Law

32. Children's Dental Anesthesia

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

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

33. 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, no benefits will be provided for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both.

34. Clinical Trials

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

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.
- A clinical trial or study approved under the *September 19, 2000, Medicare National Coverage Decision* regarding clinical trials, as amended.

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

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

Routine patient care costs for clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.

- *Agency for Healthcare Research and Quality (AHRQ)*.
- *Centers for Medicare and Medicaid Services (CMS)*.
- *Department of Defense (DOD)*.
- *Veterans Administration (VA)*.

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Benefits include Covered Health Services provided in accordance with the Covered Person's treating Physician who is providing Covered Health Services after determining that participating in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person and meets all of the following criteria:

- 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, and the general nature and extent of the risks associated with participation in the clinical trial or study.
- The Covered Person 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.
- Cost for the management of research relating to the clinical trial or study.
- 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.

35. 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.

36. 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 shall include, but not be 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 appropriate, 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.

37. 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.

38. 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 *Children's Dental Anesthesia* 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 *Children's Dental Anesthesia* 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, cranial banding and some types of braces, including over-the-counter orthotic braces.

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

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

- Trusses.
- Ultrasonic nebulizers.

4. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
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 *Food and Drug Administration (FDA)* as an "investigational new drug for treatment use"; or
- 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.

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

F. Foot Care

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

- Applying skin creams in order to maintain skin tone.

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

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

G. Medical Supplies

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

   - Elastic 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

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 that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
4. 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.
5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or

management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.

6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

8. Learning, motor skills, and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

9. 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*.

10. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee.

11. 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.
    - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    - 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 in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

    The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

I. Neurobiological Disorders - Autism Spectrum Disorders

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. Autism Spectrum Disorder services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

3. 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.

4. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

5. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

6. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

7. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.

8. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.

9. Treatment provided in connection with or to comply with involuntary commitments, police detentions, court-ordered treatment and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee.

10. 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.
    - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    - 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 in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

    The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

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, dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
    - Electric scooters.
    - 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 but not limited to 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
    - Speech therapy as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders or
    - 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. Psychosurgery.

7. Sex transformation operations.

8. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

9. Biofeedback.

10. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

11. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

12. Surgical and non-surgical treatment of obesity.

13. Stand-alone multi-disciplinary smoking cessation programs.

14. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

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

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. Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

3. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.

4. Substance Use Disorder Services for the treatment of nicotine or caffeine use.

5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee.

6. 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.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - 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 in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

   The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

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.

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.

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 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 eye glasses and contact lenses.

2. Routine vision examinations, including refractive examinations to determine the need for vision correction.

3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

4. Eye exercise or vision therapy.

5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

6. 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*.

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 treatments 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.
   - 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. 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 the 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.

12. Consultation provided 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 payments 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.

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, but not limited to, 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, 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.

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

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

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. 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.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

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

Coverage for a Disabled Dependent Child

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

- Is medically certified as Disabled.
- Depends mainly on the Subscriber or the Subscriber's spouse for support.

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

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

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

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

Extended Coverage for Total Disability

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

- The Total Disability ends.
- Three months from the date coverage would have ended when the entire Policy was terminated.

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 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 enrolled is issued to an Enrolling Group that has 50 or fewer employees, you also may 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 Annual 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.

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

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 notification or benefit confirmation prior to receiving medical care. If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.

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 in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

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. 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 will be conducted within 60 days of receipt of the request for a voluntary second level 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 7 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. 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 will be conducted within 60 days of receipt of the request for a voluntary second level review. You will be notified in writing at least 20 days in advance of the date of the review meeting. You will notified in writing of the decision within 7 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.

Voluntary 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 our voluntary 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.

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 7 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 voluntary 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 do not decide what care you need or will receive. You and your Physician make those decisions.
- 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 Annual 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 with 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 Annual 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, but not limited to:
    - 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, and
- 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.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

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

Entire Policy

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

Section 9: Defined Terms

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

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

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

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

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

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:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described 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*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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 an unmarried dependent 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.

- A Dependent includes an unmarried dependent child who is under 26 years of age only if you furnish evidence upon our request, that:
    - The child is financially dependent upon the Subscriber or the Subscriber's spouse for support and maintenance; or
- A Dependent includes an unmarried dependent child of any age 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 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.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

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 Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (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.

Intermediate Care - Mental Health or Substance Use Disorder treatment that encompasses the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment program which is continuous treatment for at least 3 hours but not more than 12 hours in any 24-hour period.
- Care through an Intensive Outpatient Treatment program.

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.

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

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 phoebia, 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 and continuous treatment for at least 3 hours but not more than 12 hours in any 24 hour period.

Pharmaceutical Product(s) - 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.

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.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

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, 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. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

Please note:

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

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

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

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).

Standard Section Names as required by Colorado Regulation 4-2-34	**UnitedHealthcare Current Section Names**
Schedule of Benefits (Who Pays What)	Schedule of Benefits
Title Page (Cover Page)	Title Page (Cover Page)
Contact Us	• Certificate of Coverage Cover Page • Certificate of Coverage - *Introduction to Your Certificate: Don't Hesitate to Contact Us*
Table of Contents	Certificate of Coverage: *Table of Contents*
Eligibility	Certificate of Coverage: *Section 3: When Coverage Begins*
How to Access Your Services and Obtain Approval of Benefits	Schedule of Benefits: *Accessing Benefits*
Benefits/Coverage (What is Covered)	Certificate of Coverage - *Section 1: Covered Health Services*
Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)	Certificate of Coverage - *Section 2: Exclusions and Limitations*
Member Payment Responsibility	Schedule of Benefits - *Benefits*
Claims Procedures (How to File a Claim)	Certificate of Coverage - *Section 5: How to File a Claim*
General Policy Provisions	Group Policy - *Article 6: General Provisions*
Termination/Nonrenewal/Continuation	Certificate of Coverage - *Section 4: When Coverage Ends*
Appeals and Complaints	Certificate of Coverage - *Section 6: Questions, Complaints and Appeals*
Information on Policy and Rate Changes	Group Policy - *Article 3: Premium Rates and Policy Charge*
Definitions	Certificate of Coverage - *Section 9: Defined Terms*

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) 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* and in this Amendment below.

Prior authorization requirements listed under *Mental Health Services and Substance Use Disorder Services* in the *Schedule of Benefits* are deleted. The following services are added to the list of services requiring pre-service notification under *Pre-service Benefit Confirmation* in the *Schedule of Benefits*:

Pre-service Benefit Confirmation

You are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home; *Applied Behavioral Analysis (ABA).*
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

***Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance Use Disorder Services* in the *Certificate, Section 1: Covered Health Services* are deleted and replaced with the following:**

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 outpatient or inpatient 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.

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 as described 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 the *Certificate*.

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

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Prescription drug product 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 for Enrolled Dependent children from birth through 18 years of age 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 health outcome. 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.

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 or legal system.

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

The following Benefit for *Autism Spectrum Disorders* is added to *Section 1: Covered Health Services* under *Additional Benefits Required Under Colorado Law* in the *Certificate*.

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* in this Amendment.

- 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 the *Certificate* 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.

***Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance Use Disorder Services* in the *Schedule of Benefits* are deleted and replaced with the following:**

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Mental Health Services			
	Inpatient **Non-Biologically Based Mental Illness or Mental Disorders** 100% after you pay a Copayment of $500 per day to a maximum Copayment of $2,500 per Inpatient Stay	Yes	No
	Biologically Based Mental Illness or Mental Disorders 100% after you pay a Copayment of $500 per day to a maximum Copayment of $2,500 per Inpatient Stay	Yes	No
	Outpatient **Non-Biologically Based Mental Illness or Mental disorders** 100% after you pay a Copayment of $50 per visit	No	No
	Biologically Based Mental Illness or Mental disorders		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	100% after you pay a Copayment of $50 per visit	No	No
Neurobiological Disorders - Autism Spectrum Disorder Services			
	Inpatient 100% after you pay a Copayment of $500 per day to a maximum Copayment of $2,500 per Inpatient Stay *Outpatient* 100% after you pay a Copayment of $50 per visit	Yes No	No No
Substance Use Disorder Services			
	Inpatient 100% after you pay a Copayment of $500 per day to a maximum Copayment of $2,500 per Inpatient Stay *Outpatient* 100% after you pay a Copayment of $50 per visit	Yes No	No No

The following *Autism Spectrum Disorders* Benefit is added to the *Schedule of Benefits* under *Additional Benefits Required under Colorado Law:*

Autism Spectrum Disorders	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.

Exclusions for *Mental Health, Neurobiological Disorders - Autism Spectrum Disorders* and *Substance Use Disorders* in the *Certificate* under *Section 2: Exclusions and Limitations* are deleted and replaced with the following:

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.

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 Enrolled Dependent children 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.

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.

The definition of *Autism Spectrum Disorders* in the *Certificate* under *Section 9: Defined Terms* is replaced with the following:

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.

The following definition of *Applied Behavioral Analysis* is added to the *Certificate* under *Section 9: Defined Terms*:

Applied Behavioral Analysis - includes the use of behavioral analytic methods and research findings to change socially important behaviors in meaningful ways.

The definition of Intermediate Care is deleted.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Patient Protection and Affordable Care Act (PPACA) 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* and in this Amendment below.

Maximum Policy Benefit/Limits on Essential Benefits

The Maximum Policy Benefit provision in the *Schedule of Benefits*, the definition of Maximum Policy Benefit in the *Certificate* and all references to a Maximum Policy Benefit are deleted. Benefits under the Policy are not limited by a Maximum Policy Benefit.

Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. In addition, any annual dollar limit applicable to the essential benefits listed below is no longer applicable. Essential benefits include the following:

> Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; 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.

Preventive Care

Benefits for preventive care that are payable at 100% of Eligible Expenses (without application of any Copayment, Coinsurance, or deductible) apply to 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*.

Dependent Children

The following *Dependent Child Special Open Enrollment* provision is added to the *Certificate, Section 3: When Coverage Begins*:

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.

The definition of Dependent is replaced with the following:

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.

Fraud or Intentional Misrepresentation of a Material Fact

The terminating provision for *Fraud, Misrepresentation or False Information* in the *Certificate, Section 4: When Coverage Ends* is replaced with the following:

- **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.

Claims and Appeals

Other changes provided for under the *PPACA* impact how claims and appeals are handled and are applicable to your plan:

- You have the right to appeal a rescission of coverage determination.
- If any new or additional evidence is relied upon or generated by us during the determination of an 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.
- With respect to any urgent request for Benefits you will receive the notice of benefit determination within 24 hours after we have received all necessary information.

Other changes provided for under the *PPACA*:

Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these provisions. 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.
- The ability to designate any primary care physician (PCP) that is accepting new patients.
- Prior authorization is not required before you receive services in the emergency department of a Hospital.
- If you seek emergency care from non-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 Network providers.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Preventive Care Services And Other Mandates Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified.

Because this Amendment 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 the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

1. *Preventive Care Services* in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

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, including prostate examinations.
- Well baby and well child care.
- Adult Immunizations.
- Hearing screening.
- Child Health Supervision Services.

Lab, X-ray or other preventive tests:

- Screening colonoscopy or sigmoidoscopy.
- 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:

- Alcohol misuse screening and behavioral counseling intervention by your Primary Physician.
- Breast cancer screening with mammography per calendar year. Please refer to your Colorado Health Benefit Plan Description Form to determine whether your Benefits are provided on a calendar year or Policy year basis.
- Cervical cancer screening.
- Cholesterol screening for lipid disorders.

- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps.
- Colorectal cancer screening in accordance with the A Recommendation or B Recommendation of the Task Force.
- Colorectal cancer screening coverage for Covered Persons who are at high risk for colorectal cancer, including Covered Persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.
- Childhood Immunizations according to the type and frequency recommended by *The Advisory Committee on Immunization Practices (ACIP)*. Benefits for immunizations for immunization deficient children are not bound by "recommended ages."
- Influenza vaccinations pursuant to the schedule established by *The Advisory Committee on Immunization Practices (ACIP)*.
- Pneumococcal vaccinations pursuant to the schedule established by *The Advisory Committee on Immunization Practices (ACIP)*.
- Tobacco use screening and tobacco cessation interventions by your Primary Physician.

2. *Preventive Care Services* in the *Schedule of Benefits* is replaced with the following:

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Preventive Care Services			
Physician office services	100%	No	No
Lab, X-ray or other preventive tests	100%	No	No
Additional Preventive Care Services	100%	No	No

3. The provision in the *Certificate* under *Additional Benefits Required By Colorado Law, Phenylketonuria (PKU) Testing and Treatment* is replaced with the following:

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 appropriate, 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.

4. The exclusion for tobacco cessation benefits in the *Certificate* under *Section 2: Drugs, Exclusions and Limitations* is replaced with the following:

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
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.

5. The exclusion for tobacco cessation benefits in the *Certificate* under *Section 2: Exclusions and Limitations, Procedures and Treatment* is deleted.

6. The exclusion copied below from the *Certificate* under *Section 2: Exclusions and Limitations, Substance Use Disorders*, is deleted and replaced as follows:

   Original exclusion:

   R. Substance Use Disorders

   4. Substance Use Disorder Services for the treatment of nicotine or caffeine use.

   New exclusion:

   R. Substance Use Disorders

   4. Substance Use Disorder Services for the treatment of caffeine use.

7. The following definitions of A Recommendation, B Recommendation, Task Force and The Advisory Committee on Immunization Practices (ACIP) are added to the *Certificate* under *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.

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.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Off Label Drugs Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified.

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.

1. The exclusion in the *Certificate*, under *Section 2: Exclusions and Limitations, Experimental or Investigational or Unproven Services*, is replaced with the following:

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* in *Section 1: Covered Health Services*.

2. The definition of Experimental or Investigational Service(s) in the *Certificate* under *(Section 9: Defined Terms)* is replaced with the following:

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 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.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Home Health Care and Hospice Care 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. 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 (limited to a maximum of $1,400 during the 12-month period following death).
- 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			
Bereavement support services are limited to $1,400 during the 12-month period following the Covered Person's death.	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), 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

2010 Certificate of Coverage Amendment

UnitedHealthcare Insurance Company

Because this Amendment reflects the requirements of the laws 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*.

1. Cleft Lip and Cleft Palate Treatment in the *Certificate*, *Section 1: Covered Health Services* is replaced with the following:

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 this policy for any dental care needed as a result of the cleft lip or cleft palate or both.

2. Clinical Trials in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

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.

3. Home Health Care in the *Certificate, Section 1: Covered Health Services* is 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 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 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.

4. Preventive Care Services in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

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 Care 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; and

- Tobacco use screening of adults and tobacco cessation interventions by your Primary Care 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.

5. Prosthetic Devices in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

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.

6. *Section 6: Questions, Complaints and Appeals*, in the *Certificate* is replaced with the following:

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 notification 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 7 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 7 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 7 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.

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

Questions, Complaints and Appeals Amendment

UnitedHealthcare Insurance Company

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

As described in this Amendment, the Policy is modified by replacing *Section 6: Questions, Complaints and Appeals* of the *Certificate of Coverage* with the provision below.

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 notification 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 benefit 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 no later than 30 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 have the right to request a voluntary second level appeal. Your voluntary 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 7 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. If you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your voluntary 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 7 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.

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.

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

Independent External Review Program

If, after the completion or exhaustion of the first level appeal or the voluntary second level 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 one of the above conditions is met, you or your designated representative may request an independent external review of adverse benefit determinations 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).

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 determinations are based on Benefit exclusions or defined Benefit limits 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 first level appeal determination.
- Within 60 calendar days after you receive notification of our voluntary second level appeal determination.
- At the same 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.

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 regarding your first level appeal or within 60 days of the date you received our adverse determination concerning your voluntary second level appeal.

1. Within two working 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 working days of receipt of the independent external review request.
3. Within one working 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 working 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 days after receipt of the independent external review request.
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:
    - Within one working day for concurrent and prospective reviews of pre-service requests for Benefits.

- Within 5 working days for retrospective reviews of post-service claims.

We will provide written notice of the approval to you and your designated representative within one working 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.

1. Within one working 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 working day of receipt of the expedited independent external review request.

3. Within one working 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 written 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. 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.

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*, in the *Schedule of Benefits* and in the *Patient Protection Affordable Care Act (PPACA) Amendment*.

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

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.

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.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify us or our designee. The reason for notifying 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.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider is responsible for notifying us.

If we are not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to our

periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If we are not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not notify us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, 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.

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 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 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.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- Copayments for Prescription Drug Products, including Specialty Prescription Drug Products.
- Coinsurance for Prescription Drug Products, including Specialty Prescription Drug Products.
- 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 Cost) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Cost. ***Copayment and Coinsurance*** 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. Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Prescription Drug Cost for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier-1 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $20.00 per Prescription Order or Refill. For a Tier-2 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $40.00 per Prescription Order or Refill. For a Tier-3 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $60.00 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $20.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $40.00 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $60.00 per Prescription Order or Refill.

Description and Supply Limits	Benefit (The Amount We Pay)
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • 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 *Specialty Prescription Drug Products.* 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.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For up to a 90-day supply, we pay: For a Tier-1 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $50.00 per Prescription Order or Refill. For a Tier-2 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $100.00 per Prescription Order or Refill. For a Tier-3 Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $150.00 per Prescription Order or Refill.

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 the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and 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 notification 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.

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

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

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

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, 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 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 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 regimens. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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.

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 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.

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. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

5. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This 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.

6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

8. Any product dispensed for the purpose of appetite suppression or weight loss.

9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

12. Unit dose packaging of Prescription Drug Products.

13. Medications used for cosmetic purposes.

14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.

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

16. Prescription Drug Products when prescribed to treat infertility.

17. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)

18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our PDL Management Committee.

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

21. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except for Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders as specified in *Section 3: Defined Terms* of this Rider.

22. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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

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 Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

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

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

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

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.

Patient Protection and Affordable Care Act (PPACA) Preventive Care Medications Addendum

UnitedHealthcare Insurance Company

As described in this addendum, Benefits for Preventive Care Medications described in the *Outpatient Prescription Drug Rider* and *Outpatient Prescription Drug Schedule of Benefits* are modified as stated below.

Because this addendum 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 addendum below.

Benefits for Preventive Care Medications

Benefits under the *Outpatient Prescription Drug Rider* include those for Preventive Care Medications as defined below. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Defined Terms

The following definition of Preventive Care Medications is added to the Outpatient Prescription Drug Rider:

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 or by calling *Customer Care* at the telephone number on your ID card.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

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

IMPORTANT NOTICE: If you have a dependent child whose coverage ended or who was denied coverage (or was not eligible for coverage) because dependent coverage of children was not available up to age 26, you may have the right to enroll that dependent under a special dependent child enrollment period. This right applies as of the first day of the first plan year beginning on or after September 23, 2010 and your employer (or enrolling group) must provide you with at least a 30 day enrollment period. If you are adding a dependent child during this special enrollment period and have a choice of coverage options under the plan, you will be allowed to change options. This child special open enrollment may coincide with your annual open enrollment, if you have one. Please contact your employer or group plan administrator for more information.

IMPORTANT NOTICE: If coverage or benefits for you or a dependent ended due to reaching a lifetime limit, be advised that a lifetime limit on the dollar value of benefits no longer applies. If you are covered under the plan, you are once again eligible for benefits. Additionally, if you are not enrolled in the plan, but are still eligible for coverage, then you will have a 30 day opportunity to request enrollment. This 30 day enrollment opportunity will begin no later than the first day of the first plan year beginning on or after September 23, 2010. This 30 day enrollment period may coincide with your annual open enrollment, if you have one. Please contact your employer or group health plan administrator for more information.

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; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; 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.

- Any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to covered persons under the age of 19.

- 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*.

  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.

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. 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. 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.

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

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, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical 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. 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. 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.

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.

We* 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 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 a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on our website www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

**For purposes of this Notice of Privacy Practices, "we" or "us" refers 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; American Medical Security Life Insurance Company; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Evercare of New Mexico, Inc.; Evercare of Texas, LLC; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, 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; Physicians Health Choice of Texas, LLC; Sierra Health & Life Insurance Co., Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Family Health Plan of Pennsylvania, Inc.; Unison Health Plan of Delaware, Inc.; Unison Health Plan of Pennsylvania, Inc.; Unison Health Plan of Tennessee, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, Inc.; *UnitedHealthcare Community Plan of Ohio, Inc.*; *UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Great Lakes Health Plan, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, 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 South Carolina, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.*

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 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.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **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.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

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:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;

- Sexually transmitted diseases and reproductive health information; and
- 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 summary of federal and state laws on use and disclosure of certain types of medical information.

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. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at anytime 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. We will accept verbal requests to receive confidential communications, but 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 health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend** information we maintain about you 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) prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) 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 at our website, **www.myuhc.com**.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on the back of your ID card or you may contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.
- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for 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.

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.

We** are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means 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.
- 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.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the **Health Plan Notices of Privacy Practices**, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; National Pacific Dental, Inc.; Nevada Pacific Dental; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; 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.*

Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with state and federal standards to guard your personal financial information. We conduct regular audits to help ensure appropriate and secure handling and processing of our enrollees' information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free phone number on the back of your ID card or you may contact the *UnitedHealth Group Customer Call Center* at 866-633-2446.

UnitedHealth Group

Health Plan Notice of Privacy Practices: Federal and State Amendments

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.
- Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	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 health information.	NV
We are not allowed to use health information for certain purposes.	CA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	MO, NJ, SD
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV

Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, HI, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, GA, HI, KY, IL, IN, IA, LA, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, HI, 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
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WA, WI, WV, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, HI, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

UNITED HEALTHCARE INSURANCE COMPANY AGREEMENT
EXHIBIT E

ACORD Certificates of Liability Insurance

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 05/01/2012

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).

PRODUCER	CONTACT NAME:	
MARSH USA INC. 99 HIGH STREET BOSTON, MA 02110 Attn: Healthcare.accountsCSS@marsh.com FAX 212-948-1307 401115-CRIME-CORP-12-13	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : National Union Fire Ins Co Pittsburgh PA	19445
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

INSURED
UNITEDHEALTH GROUP INCORPORATED ATTN: RISK MANAGEMENT 9900 BREN ROAD EAST MN008-T425 MINNETONKA, MN 55343

COVERAGES **CERTIFICATE NUMBER:** CHI-004421635-01 **REVISION NUMBER:** 1

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	
	GENERAL LIABILITY							
	☐ COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N **(Mandatory in NH)**	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	CRIME			01-830-69-37	05/01/2012	05/01/2013	LIMIT PER OCCURRENCE	$5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, If more space is required)

CERTIFICATE HOLDER

UNITEDHEALTH GROUP INCORPORATED
ATTN: RISK MANAGEMENT
9900 BREN ROAD EAST MN008-T425
MINNETONKA, MN 55343

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.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

ACORD EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY): 02/28/2012

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	PHONE (A/C, No, Ext): 877-945-7378	COMPANY NAME AND ADDRESS	NAIC NO: 21482-002
Willis of Minnesota, Inc. c/o 26 Century Blvd. P. O. Box 305191 Nashville, TN 37230-5191		Factory Mutual Insurance Company 300 S. Norwest Hwy Park Ridge, IL 60068	
FAX (A/C, No): 888-467-2378	E-MAIL ADDRESS: certificates@willis.com	IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	
CODE:	SUB CODE:	POLICY TYPE: Commercial Property	
AGENCY CUSTOMER ID #:			
NAMED INSURED AND ADDRESS EVIDENCE OF INSURANCE FOR UnitedHealth Group 9900 Bren Road East Minneapolis, MN 55440-1459		LOAN NUMBER	POLICY NUMBER: FS233
		EFFECTIVE DATE: 03/01/2012	EXPIRATION DATE: 03/01/2013 — ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)		THIS REPLACES PRIOR EVIDENCE DATED:	

PROPERTY INFORMATION (Use REMARKS on page 2, if more space is required) [x] BUILDING OR [x] 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 [x] SPECIAL ☐

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 100,000,000 DED: $100,000

	YES	NO	N/A			
[x] BUSINESS INCOME [x] RENTAL VALUE	x			If YES, LIMIT: Included	x	Actual Loss Sustained; # of months12
BLANKET COVERAGE	x			If YES, indicate value(s) reported on property identified above: $Included		
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: Included		DED: $100,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	x					
- Demolition Costs	x			If YES, LIMIT: Included		DED: $100,000
- Incr. Cost of Construction	x			If YES, LIMIT: Included		DED: $100,000
EARTH MOVEMENT (If Applicable)	x			If YES, LIMIT: $2,500,000		DED: 5%
FLOOD (If Applicable)	x			If YES, LIMIT: $2,500,000		DED: $500,000
WIND / HAIL (If Subject to Different Provisions)			x	If YES, LIMIT:		DED:
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	

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 02/22/2013

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).

PRODUCER Marsh USA Inc. 333 South 7th Street, Suite 1600 Minneapolis, MN 55402-2400 401115--Cyber-12-14	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED UNITEDHEALTH GROUP 9900 BREN ROAD EAST MN008 T425 MINNETONKA, MN 55343	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A : Old Republic Insurance Co — 24147 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** CHI-004642369-01 **REVISION NUMBER:** 3

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	
	GENERAL LIABILITY							
	☐ COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	CYBER LIABILITY			MWZZ51089	11/01/2012	05/01/2014	EACH CLAIM	5,000,000
							AGGREGATE	5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

EVIDENCE OF INSURANCE

CERTIFICATE HOLDER

UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008 T425
MINNETONKA, MN 55343

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.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/26/2012

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).

PRODUCER
MARSH USA INC.
333 SOUTH 7TH STREET, SUITE 1600
MINNEAPOLIS, MN 55402-2427
Attn: Healthcare.AccountsCSS@Marsh.com/FAX 212-948-1307

401115-5M–GAWX5-12-13

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Old Republic Insurance Co	24147
INSURER B : American Guarantee & Liability Ins Co	26247
INSURER C : Travelers Property Casualty Company Of America	25674
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008-T425
MINNETONKA, MN 55343

COVERAGES **CERTIFICATE NUMBER:** CHI-004418127-03 **REVISION NUMBER:** 5

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	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			MWZY59664	05/01/2012	05/01/2014	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 3,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			MWTB21537	05/01/2012	05/01/2014	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 2,000,000 $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			AUC596527904	05/01/2012	05/01/2013	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
C C C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		HC2JUB472M475512 (AOS) HRJUB472M476712 (MA & WI) HWXJUB472M477912 (XWC OH)	05/01/2012 05/01/2012 05/01/2012	05/01/2013 05/01/2013 05/01/2013	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

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.

CERTIFICATE HOLDER

UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008 T425
MINNETONKA, MN 55343

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.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Manashi Mukherjee Manashi Mukherjee

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/09/2013

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(les) 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).

PRODUCER
Marsh USA Inc.
333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2400
Attn: Healthcare.AccountsCSS@marsh.com Fax 212-948-1307

401115-OLD-PL5M-12-14

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Old Republic Insurance Co	24147
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008 T425
MINNETONKA, MN 55343

COVERAGES **CERTIFICATE NUMBER:** CHI-004227576-08 **REVISION NUMBER:** 9

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	
	GENERAL LIABILITY							
	☐ COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ **(Mandatory in NH)**	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Managed Care			MWZZ50659	05/01/2012	05/01/2014	Each Claim	$5,000,000
	Professional Liability/E&O			RETRO DATE: 1/1/77			Annual Aggregate	$5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008 T425
MINNETONKA, MN 55343

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.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Manashi Mukherjee Manashi Mukherjee