United HealthCare Insurance Company

450 Columbus Boulevard

Hartford, Connecticut 06115-0450

1-800-357-1371

Disclosure of Minimum Creditable Coverage Standards

✓ This benefit plan design meets Minimum Creditable Coverage (MCC) standards and will satisfy the individual Massachusetts mandate that you have health insurance. Please see below for additional information.

Massachusetts Requirement to Purchase Health Insurance:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage (MCC) standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website at www.mahealthconnector.org.

This benefit plan design meets MCC standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase (or, if this health plan is offered to you through your place of employment, your employer purchases) this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

UnitedHealthcare Choice

UnitedHealthcare Insurance Company

Schedule of Benefits

CW- XD , $2,500

How Do You Access Benefits?

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

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

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

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

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

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

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

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

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

Does Prior Authorization Apply?

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

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

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. 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 the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	$2,500 per Covered Person, not to exceed $5,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services.	$8,700 per Covered Person, not to exceed $17,400 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts
• Charges that exceed Allowed Amounts, when applicable. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	

Co-payment

Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.

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

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

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Co-insurance

Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
In most cases, we will initiate and direct non-Emergency ambulance transportation.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Ground Ambulance* None	Yes	Yes
	Air Ambulance None	Yes	Yes
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Ground Ambulance* None	Yes	Yes
	Air Ambulance None	Yes	Yes
2. Cellular and Gene Therapy			

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Cellular or Gene Therapy services must be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
3. Clinical Trials			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
4. Congenital Heart Disease (CHD) Surgeries			
It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*		
5. Dental Services - Accident Only			
Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.	None	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
6. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.* Benefits for blood glucose monitors will be same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.*		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
You must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	None	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within two business days. Notification provided to us by the attending physician will satisfy this requirement. We may elect to transfer you to a Network Hospital as soon as it is medically	$400 per visit .	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*			
9. Enteral Nutrition			
	None	Yes	Yes
10. Fertility Preservation for Iatrogenic Infertility			
Benefits are limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire time he or she is enrolled for coverage under the Policy.	None	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
11. Habilitative Services			
Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 60 days per year.	*Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient therapies are limited per year as follows: • 44 visits of physical therapy. • 44 visits of occupational therapy. • Unlimited Manipulative Treatments. • Unlimited visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive therapy. When physical and/or occupational therapy is furnished as part of the treatment of an autism spectrum disorder, a benefit limit will not apply to these services.	*Outpatient* $35 per visit	Yes	No

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
12. Hearing Aids			
Note: Limited to $2,000 per hearing aid per hearing impaired ear every 36 months. The difference above the limit of $2,000 will be payable by the insured if the insured elects to pay the difference.	None	Yes	Yes
13. Home Health Care			
For the administration of intravenous infusion, you must receive services from a provider we identify.	None	Yes	Yes
14. Hospice Care			
	None	Yes	Yes
15. Hospital - Inpatient Stay			
Note: Any deductible, copayment, and/or coinsurance, whichever applies to you, will be waived sterilization procedure for a female member when performed as the primary procedure for family planning reasons.	$500 per Inpatient Stay	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
16. Infertility Services			
	None	Yes	Yes
17. Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient	$35 per service at a freestanding lab or in a Physician's office	Yes	No
	None at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	$75 per service at a freestanding diagnostic center or in a Physician's office	Yes	No

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	None at an outpatient Hospital-based diagnostic center	Yes	Yes
18. Major Diagnostic and Imaging - Outpatient			
	$500 per service at a freestanding diagnostic center or in a Physician's office	Yes	No
	None at an outpatient Hospital-based diagnostic center	Yes	Yes
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient $500 per Inpatient Stay	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Outpatient $35 per visit	Yes	No
	None for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
20. Obesity - Weight Loss Surgery			
It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
Obesity - weight loss surgery must be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
21. Ostomy Supplies			
	None	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
22. Pharmaceutical Products - Outpatient			
	None None for oral chemotherape-utic agents	Yes	Yes , except for oral chemotherape-utic agents
23. Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	None	Yes	Yes
24. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office : • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.*	$35 per visit for a Primary Care Provider office visit or $75 per visit for a Specialist office visit $35 per visit for a Primary Care Physician Telehealth/Tele-medicine visit	Yes	No

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• 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.*			
25. Pregnancy - Maternity Services Includes: Childbirth Classes			
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
26. Preimplantation Genetic Testing (PGT) and Related Services			
	None	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
27. Preventive Care Services Includes: Fitness Benefit Weight Loss Program Benefit			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No
Breast pumps	None	Yes	No
28. Prosthetic Devices			
	None	Yes	Yes
29. Reconstructive Procedures			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
30. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 20 visits of pulmonary rehabilitation therapy. • Unlimited visits of cardiac rehabilitation therapy. • 44 visits of physical therapy. • 44 visits of occupational therapy. • Unlimited Manipulative Treatments. • Unlimited visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. When physical and/or occupational therapy is furnished as part of the treatment of an autism spectrum disorder or as part of home health care, a benefit limit will not apply to these services.	$35 per visit	Yes	No
31. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	$500 at a freestanding center or in a Physician's office	Yes	No

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	None at an outpatient Hospital-based center	Yes	Yes
32. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • 100 days per year in a Skilled Nursing Facility. • 60 days per year in an Inpatient Rehabilitation Facility.	$500 per Inpatient Stay	Yes	Yes
33. Surgery - Outpatient			
Note: Any deductible, copayment, and/or coinsurance, whichever applies to you, will be waived sterilization procedure for a female member when performed as the primary procedure for family planning reasons.	None at an ambulatory surgical center or in a Physician's office	Yes	Yes
	None at an outpatient Hospital-based surgical center	Yes	Yes
34. Temporomandibular Joint (TMJ) Services			

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
35. Therapeutic Treatments - Outpatient			
	None	Yes	Yes
36. Transplantation Services			
Transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
37. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures	$75 per visit	Yes	No

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*			
38. Urinary Catheters			
	None	Yes	Yes
39. Virtual Care Services			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	None	Yes	No
Additional Benefits Required By Massachusetts Law			
40. Autism Spectrum Disorder Treatment			
This benefit is unlimited. Limits stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in your *Schedule of Benefits* do not apply to *Autism Spectrum Disorder Treatment.*	Depending upon where the Covered Health Care Service is provided Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
41. Early Intervention Services			
	None	Yes	No
42. HIV-Associated Lipodystrophy Treatment	Depending upon where the Covered Health Care Service is provided, will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
43. Hormone Replacement Therapy and Contraceptive Services			
	Depending upon where the Covered Health Care Service is provided Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
44. Hypodermic Needles and Syringes			
	None	Yes	Yes
45. Lyme Disease Treatment	Depending upon where the Covered Health Care Service is provided Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
46. Speech, Hearing, and Language Disorders			
	Depending upon where the Covered Health Care Service is provided Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
47. Treatment of Cleft Lip or Palate or Both			
	Depending upon where the Covered Health Care Service is provided Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
48. Wigs			
	None	Yes	Yes

Allowed Amounts

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

- For Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians,*** you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below,*** you are not

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

- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider,*** you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider,*** you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate.*

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

For Benefits, Allowed Amounts are based on the following:

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

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

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

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

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

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

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

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

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in

excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*

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

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

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

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

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

Provider Network

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

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

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

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

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

Continuity of Care

Network Benefits for continued treatment are provided in the following situations:

- If a Covered Person is in her second or third trimester of pregnancy and receiving obstetrical care from a provider who is involuntarily disenrolled from the Network, other than disenrollment for quality-related reasons or for fraud, the Covered Person may continue to be treated by that provider for that pregnancy up to and including the first postpartum visit.
- If a Covered Person is receiving care for a terminal illness from a provider who is involuntarily disenrolled from the Network, other than disenrollment for quality-related reasons or for fraud, the Covered Person may continue to be treated by that provider until the Covered Person's death.
- Network Benefits will be paid for services of an out-of-Network Physician for the time period shown below beginning on the effective date of coverage for a new Eligible Person if the Enrolling Group only offers a choice of carriers in which the Physician is not a participating provider and one of the following situations applies:
    - Up to 30 days if the Physician is providing the Covered Person an ongoing course of treatment or is the Covered Person's Primary Care Provider.
    - Through the first postpartum visit for a Covered Person in her second or third trimester of pregnancy.
    - Until the Covered Person's death for a Covered Person with a terminal illness.

This Continued Treatment provision only applies if the provider agrees to the following three conditions:

- To accept reimbursement from us at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Covered Person in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled.
- To adhere to our quality assurance standards and to provide us with necessary medical information related to the care provided.
- To adhere to our policies and procedures, including procedures regarding referrals, obtaining prior authorization and services provided pursuant to a treatment plan, if any, approved by us.

This Continued Treatment provision will not be construed to require the coverage of Benefits that would not have been covered if the provider involved remained a Network provider.

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

Designated Providers

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

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

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

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider. We will cover the non-Network Covered Health Care Service and you will not be responsible to pay more than the amount which would be required for a similar Covered Health Care Service offered within our network. In addition, whenever a location is part of our network, we will cover a Covered Health Care Service delivered at that location and you will

not be responsible to pay more than the amount required for Network services even if part of the Covered Health Care Service is performed by non-Network providers, unless you had a reasonable opportunity to choose to have the service performed by a 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 Care Services.

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

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