UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

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 Insurance Company

Choice Plus

Group Medical Policy

Schedule of Benefits

CV- 6T , $0

How Do You Access Benefits?

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network 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 Network Benefits.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

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 8: Defined Terms* of the *Policy* 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.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. 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. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. 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 ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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 received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

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

Care Management

When you seek prior authorization as required, we will work with you to put in place 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 requirements 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 Care Services.

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.

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

Benefit limits are calculated on a 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 Out-of-Network 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.	***Network*** No Annual Deductible. ***Out-of-Network*** $3,000 per Covered Person, not to exceed $6,000 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,* the *Pediatric Vision Care Services Rider* and the *Pediatric Dental Services Rider* and the *Routine Vision Examination 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. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, when applicable.	***Network*** $5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family. ***Out-of-Network*** $15,000 per Covered Person, not to exceed $30,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts
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 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.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
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.*	***Network*** *Ground Ambulance* None	Yes	No
	Air Ambulance None	Yes	No
	Out-of-Network Same as Network	Same as Network	Same as Network

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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.*	***Network*** *Ground Ambulance* None	Yes	No
	Air Ambulance None	Yes	No
	Out-of-Network *Ground Ambulance* 20%	Yes	Yes
	Air Ambulance Same as Network	Same as Network	Same as Network

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
2. Cellular and Gene Therapy			

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	***Network*** 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.*
	Out-of-Network 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	

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** 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.*		
	Out-of-Network 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			

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

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.*	***Network*** Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 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.	***Network*** None	Yes	No
	Out-of-Network Same as Network	Same as Network	Same as Network
6. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network 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 Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.*	***Network*** 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.*		
	Out-of-Network 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.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
7. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
To receive Network Benefits, you must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	***Network*** 20%	Yes	No
	Out-of-Network 20%	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 the requirement. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a	***Network*** $350 per visit .	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Covered Health Care Service. 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.*			
	Out-of-Network Same as Network	Same as Network	Same as Network
9. Enteral Nutrition			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
10. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
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.	***Network*** None	Yes	No
	Out-of-Network 20%	Yes	Yes
11. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 60 days per year.	***Network*** *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* $55 per visit	Yes	No
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient 20%	Yes	Yes
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.	***Network*** None	Yes	No
	Out-of-Network 20%	Yes	Yes
13. Home Health Care			
Prior Authorization Requirement For Out-Of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	***Network*** None	Yes	No
	Out-of-Network 20%	Yes	Yes
14. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
15. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Note: Any deductible, Co-payment, and/or Co-insurance, whichever applies to you, will be waived for a sterilization procedure for a female member when performed as the primary procedure for family planning reasons.	***Network*** $750 per Inpatient Stay	Yes	No
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
16. Infertility Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes
17. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography, and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient			
	Network $25 per service	Yes	No

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

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	***Network*** $75 per service	Yes	No
	Out-of-Network 20%	Yes	Yes
18. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA, nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network $250 per service	Yes	No

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network 20%	Yes	Yes
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network *Inpatient* $750 per Inpatient Stay	Yes	No
	Outpatient $30 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	None for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	No
	Out-of-Network *Inpatient* 20%	Yes	Yes
	Outpatient 20%	Yes	Yes
	20% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
20. Obesity - Weight Loss Surgery			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization six months prior to surgery or as soon as the possibility of obesity - weight loss surgery arises. If you do not obtain prior authorizatio n as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay. **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.**			
	Network 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.*		
	Out-of-Network 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			
	Network None	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
22. Pharmaceutical Products - Outpatient			
	Network None None for oral chemotherapeutic agents	Yes	No
	Out-of-Network 20%	Yes	Yes, except when provided during a Physician office visit
23. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Co-payment,	***Network*** None	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Co-insurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*			
	Out-of-Network 20%	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.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under	***Network*** $30 per visit for a Primary Care Provider office visit or $55 per visit for a Specialist office visit $30 per visit for a Primary Care Provider Telehealth/Tele-medicine visit	Yes	No

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Surgery - Outpatient. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*			
	Out-of-Network 20%	Yes	Yes
25. Pregnancy - Maternity Services Includes: Childbirth Classes			

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

	Network Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
26. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
27. Preventive Care Services Includes: Fitness Benefit Weight Loss Program Benefit			
Physician office services	***Network*** None	Yes	No
	Out-of-Network 20%	Yes	Yes
Lab, X-ray or other preventive tests	***Network*** None	Yes	No
	Out-of-Network 20%	Yes	Yes
Breast pumps	***Network*** None	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
28. Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
29. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
	Network 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.*		
	Out-of-Network 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.*		
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.	***Network*** $55 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• 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.			
	Out-of-Network 20%	Yes	Yes
31. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network None	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
32. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Limited to: • 100 days per year in a Skilled Nursing Facility. • 60 days per year in an Inpatient Rehabilitation Facility.	***Network*** $750 per Inpatient Stay	Yes	No
	Out-of-Network 20%	Yes	Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
33. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Note: Any deductible, Co-payment, and/or Co-insurance, whichever applies to you, will be waived for a sterilization procedure for a female member when performed as the primary procedure for family planning reasons.	***Network*** $500 per date of service.	Yes	No
	Out-of-Network 20%	Yes	Yes
34. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you do not notify us as required, you will be responsible for paying all charges and no Benefits will be paid. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network 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.*		
	Out-of-Network 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			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network None	Yes	No

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
36. Transplantation Services			

Prior Authorization Requirement

For Out-of-Network Benefits, you must 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). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	***Network*** 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.*
	Out-of-Network 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.*

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
37. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*	***Network*** $55 per visit	Yes	No
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
38. Urinary Catheters			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes
39. Virtual Care Services			
Network 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.	***Network*** None	Yes	No
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Additional Benefits Required By Massachusetts Law			
40. Autism Spectrum Disorder Treatment			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.			
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.*	***Network*** 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.*		
	Out-of-Network 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.*		
41. Early Intervention Services			
	Network None	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network None	Yes	No
42. HIV-Associated Lipodystrophy Treatment			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.			
	Network 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.*		
	Out-of-Network 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.*		
43. Hormone Replacement Therapy and Contraceptive Services			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** 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.*		
	Out-of-Network 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			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
45. Lyme Disease Treatment			
	Network 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.*		
	Out-of-Network 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.*		
46. Speech, Hearing, and Language Disorders			
	Network 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.*		
	Out-of-Network 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.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
47. Treatment of Cleft Lip or Palate or Both			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.			
	Network 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.*		
	Out-of-Network 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			
	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes

Allowed Amounts

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

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

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

Network Benefits

Allowed Amounts are based on the following:

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

Out-of-Network Benefits

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 *Policy.*

- **For Emergency Health Care Services provided by an out-of-Network provider,** the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Policy.*
- **For Air Ambulance transportation provided by an out-of-Network provider,** the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Policy.*
- For Emergency ground ambulance transportation provided by an out-of-Network provider, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined based on either of the following:

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates, or subcontractors.
- If rates have not been negotiated, then one of the following amounts:

- Allowed Amounts are determined based on 150% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
- When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS,* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book),* or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
  - When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
  - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section *2799B-2(d) of the Public Health Service Act.*

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 Network 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 show 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, Network 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, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the *Policy.*

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network 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.

If a Covered Health Care Service is not available to you within our Network, we will cover the out-of- 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 out-of-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, Covered Health Care Services will be paid as Out-of-Network Benefits.

Kidney Donor Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides a donor travel and lodging allowance related to living kidney transplantation.

Because this Rider 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* in *Section 9: Defined Terms.*

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

Kidney Donor Travel and Lodging Program

The *Kidney Donor Travel and Lodging Program* provides support for living kidney donors when the intended recipient of the kidney is a Covered Person under the Policy. The program provides an allowance for travel and lodging expenses for an approved living kidney donor and travel companion. The living kidney donor is not required to be a Covered Person under the Policy.

Donors must be approved by us for participation in this program. This program provides an allowance for incurred travel and lodging expenses only and is independent of any existing medical coverage available for the donor or Covered Person. Once approved, an allowance of up to $6,000 per donor will be provided for travel and lodging expenses incurred as a part of the entire kidney donation process, based on the *U.S. General Services Administration* travel rates. Expenses incurred will include travel and lodging expenses for the donor's first evaluation through follow-up evaluation(s) up to two years after donor surgery.

If you would like additional information regarding the *Kidney Donor Travel and Lodging Program*, you may contact us at www.myuhc.com.

Jessica Paik, President

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

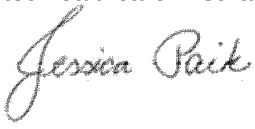
This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online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

These Covered Health Care Services will be individualized and may include the following:

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

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company



Jessica Paik, President

Routine Vision Exam Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

This Rider to the Policy is issued to the Group and provides Benefits for routine vision exams, as described below for Covered Persons over the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this Rider in *Section 4: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms.*

Jessica Paik, President

Section 1: Benefits for Routine Vision Exams

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

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

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

Annual Deductible

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

What Are the Benefit Descriptions?

Benefits

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

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

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-payments and Co-insurance stated below.

Routine Vision Exam

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

- A patient history that includes reasons for the exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).

- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the internal eye.
- Visual Field testing.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Routine Vision Exam or Refraction only in lieu of a complete exam.	Once every 12 months.	$30 per exam. Not subject to payment of the Annual Deductible.	20% of the billed charge.

Section 2: Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Routine Vision Exams,* Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the *Policy.*

Section 3: Claims for Routine Vision Exams

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek payment from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Routine Vision Exams

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

- Your itemized receipts.

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

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

UnitedHealthcare Vision Network - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under this Rider.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service(s) - routine vision exams listed in this Rider in *Section 1: Benefits for Routine Vision Exams.*

Pediatric Dental Services Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

This Rider to the Policy provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Massachusetts Health Connector.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Policy* in *Section 8: Defined Terms* or in this Rider in *Section 5: Defined Terms for Pediatric Dental Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms.*

Jessica Paik, President

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

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

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

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

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

Out-of-Network Benefits - these Benefits apply when you decide to obtain Covered Dental Services from out-of-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. You may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service that is greater than the Usual and Customary fee. When you obtain Covered Dental Services from out-of-Network Dental Providers, you must file a claim with us to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

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

Section 2: Benefits for Pediatric Dental Services

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

A. Necessary.

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

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

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

Network Benefits:

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

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

Out-of-Network Benefits:

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

Annual Deductible

Benefits for pediatric Dental Services provided under this Rider are subject to the Annual Deductible stated in the *Schedule of Benefits,* unless otherwise specifically stated.

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

Benefits

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

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

Benefit Description

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Diagnostic Services - Out-of-Network (Subject to payment of the Annual Deductible.)		
Evaluations (Checkup Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation. D0140 - Limited oral evaluation - problem focused. D9995 - Teledentistry - synchronous - real time encounter. D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. D0150 - Comprehensive oral evaluation - new or established patient. D0180 - Comprehensive periodontal evaluation - new or established patient. The following service is not subject to a frequency limit. D0160 - Detailed and extensive oral evaluation - problem focused, by report.	None	20%
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Intraoral - complete series of radiographic images.	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D0709 - Intraoral - complete series of radiographic images - image capture only.		
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first radiographic image. D0230 - Intraoral - periapical - each additional radiographic image. D0240 - Intraoral - occlusal radiographic image. D0706 - Intraoral - occlusal radiographic image - image capture only. D0707 - Intraoral - periapical radiographic image - image capture only.	None	20%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewing - single radiographic image. D0272 - Bitewings - two radiographic images. D0274 - Bitewings - four radiographic images. D0277 - Vertical bitewings - 7 to 8 radiographic images. D0708 - Intraoral - bitewing radiographic image - image capture only.	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image. D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only. D0704 - 3-D Photographic image - image capture only.	None	20%
The following services are limited to two images per calendar year. D0705 - Extra-oral posterior dental radiographic image - image capture only.	None	20%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis . D0350 - 2-D Oral/facial photographic images obtained intra-orally or extra-orally. D0470 - Diagnostic casts. D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Preventive Services - Out-of-Network (Subject to payment of the Annual Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult. D1120 - Prophylaxis - child.	None	20%
Fluoride Treatments The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish. D1208 - Topical application of fluoride - excluding varnish.	None	20%
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth. D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth.	None	20%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed, unilateral - per quadrant. D1516 - Space maintainer - fixed - bilateral, maxillary. D1517 - Space maintainer - fixed -	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
bilateral, mandibular. D1520 - Space maintainer - removable, unilateral - per quadrant. D1526 - Space maintainer - removable - bilateral, maxillary. D1527 - Space maintainer - removable - bilateral, mandibular. D1551 - Re-cement or re-bond bilateral space maintainer - maxillary. D1552 - Re-cement or re-bond bilateral space maintainer - mandibular. D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant. D1556 - Removal of fixed unilateral space maintainer - per quadrant. D1557 - Removal of fixed bilateral space maintainer - maxillary. D1558 - Removal of fixed bilateral space maintainer - mandibular. D1575 - Distal shoe space maintainer - fixed - unilateral - per quadrant.		
Minor Restorative Services - Out-of-Network (Subject to payment of the Annual Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent. D2150 - Amalgams - two surfaces, primary or permanent. D2160 - Amalgams - three surfaces,	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
primary or permanent. D2161 - Amalgams - four or more surfaces, primary or permanent.		
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior. D2331 - Resin-based composite - two surfaces, anterior. D2332 - Resin-based composite - three surfaces, anterior. D2335 - Resin-based composite - four or more surfaces or involving incisal angle, (anterior).	20%	40%
Crowns/Inlays/Onlays - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces. D2543 - Onlay - metallic - three surfaces. D2544 - Onlay - metallic - four or more surfaces. D2740 - Crown - porcelain/ceramic. D2750 - Crown - porcelain fused to high noble metal. D2751 - Crown - porcelain fused to predominately base metal. D2752 - Crown - porcelain fused to noble metal. D2753 - Crown - porcelain fused to	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
titanium and titanium alloys. D2780 - Crown - 3/4 cast high noble metal. D2781 - Crown - 3/4 cast predominately base metal. D2783 - Crown - 3/4 porcelain/ceramic. D2790 - Crown - full cast high noble metal. D2791 - Crown - full cast predominately base metal. D2792 - Crown - full cast noble metal. D2794 - Crown - titanium and titanium alloys. D2930 - Prefabricated stainless steel crown - primary tooth. D2931 - Prefabricated stainless steel crown - permanent tooth. The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface. D2520 - Inlay - metallic - two surfaces. D2530 - Inlay - metallic - three surfaces. D2910 - Re-cement or re-bond inlay. D2920 - Re-cement or re-bond crown.		
The following service is not subject to a frequency limit. D2940 - Protective restoration.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is limited to one time per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth. D2950 - Core buildup, including any pins when required.	50%	50%
The following service is limited to one time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to restoration.	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown.	50%	50%
The following service is not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure. D2981 - Inlay repair necessitated by restorative material failure. D2982 - Onlay repair necessitated by restorative material failure.	50%	50%
Endodontics - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration).	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	20%	40%
The following service is not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	20%	40%
The following service is not subject to a frequency limit. D3310 - Endodontic therapy anterior tooth (excluding final restoration). D3320 - Endodontic therapy, premolar tooth (excluding final restoration). D3330 - Endodontic therapy, molar tooth (excluding final restoration). D3346 - Retreatment of previous root canal therapy - anterior. D3347 - Retreatment of previous root canal therapy - bicuspid. D3348 - Retreatment of previous root canal therapy - molar.	20%	40%
The following service is not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 -	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Apexification/recalcification/pulpal regeneration - interim medication replacement. D3353 - Apexification/recalcification - final visit.		
The following service is not subject to a frequency limit. D3410 - Apicoectomy - anterior. D3421 - Apicoectomy - premolar (first root). D3425 - Apicoectomy - molar (first root). D3426 - Apicoectomy (each additional root). D3450 - Root amputation - per root. D3471 - Surgical repair of root resorption - anterior. D3472 - Surgical repair of root resorption - premolar. D3473 - Surgical repair of root resorption - molar. D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	20%	40%
The following service is not subject to a frequency limit. D3911 - Intraorifice barrier.	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D3920 - Hemisection (including any root removal), not including root canal therapy.		
Periodontics - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	20%	40%
The following service is limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant. D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant. D4249 - Clinical crown lengthening - hard tissue.	20%	40% 40%
The following service is limited to one every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant. D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant.	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D4263 - Bone replacement graft - retained natural tooth - first site in quadrant.		
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure.	20%	40%
The following service is not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft. D4275 - Non-autogenous connective tissue graft first tooth implant. D4277 - Free soft tissue graft procedure - first tooth. D4278 - Free soft tissue graft procedure - each additional contiguous tooth. D4322 - Splint - intra-coronal; natural teeth or prosthetic crowns. D4323 - Splint - extra-coronal; natural teeth or prosthetic crowns.	20%	40%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant. D4342 - Periodontal scaling and root planing - one to three teeth per quadrant. D4346 - Scaling in presence of	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.		
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit.	20%	40%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance.	20%	40%
Removable Dentures - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary. D5120 - Complete denture - mandibular. D5130 - Immediate denture - maxillary. D5140 - Immediate denture - mandibular. D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
and teeth). D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth). D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth). D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary. D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary. D5411 - Adjust complete denture - mandibular. D5421 - Adjust partial denture - maxillary. D5422 - Adjust partial denture - mandibular. D5511 - Repair broken complete denture base - mandibular. D5512 - Repair broken complete denture base - maxillary. D5520 - Replace missing or broken teeth - complete denture (each tooth). D5611 - Repair resin partial denture base - mandibular. D5612 - Repair resin partial denture base - maxillary. D5621 - Repair cast partial framework - mandibular. D5622 - Repair cast partial framework - maxillary. D5630 - Repair or replace broken	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
retentive/clasping materials - per tooth. D5640 - Replace broken teeth - per tooth. D5650 - Add tooth to existing partial denture. D5660 - Add clasp to existing partial denture.		
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture. D5711 - Rebase complete mandibular denture. D5720 - Rebase maxillary partial denture. D5721 - Rebase mandibular partial denture. D5725 - Rebase hybrid prosthesis. D5730 - Reline complete maxillary denture (direct). D5731 - Reline complete mandibular denture (direct). D5740 - Reline maxillary partial denture (direct). D5741 - Reline mandibular partial denture (direct). D5750 - Reline complete maxillary denture (indirect). D5751 - Reline complete mandibular denture (indirect).	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D5760 - Reline maxillary partial denture (indirect). D5761 - Reline mandibular partial denture (indirect). D5876 - Add metal substructure to acrylic full denture (per arch).		
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect. D5850 - Tissue conditioning (maxillary). D5851 - Tissue conditioning (mandibular).	50%	50%
Bridges (Fixed partial dentures) - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal. D6211 - Pontic - cast predominately base metal. D6212 - Pontic - cast noble metal. D6214 - Pontic - titanium and titanium alloys. D6240 - Pontic - porcelain fused to high noble metal. D6241 - Pontic - porcelain fused to predominately base metal. D6242 - Pontic - porcelain fused to noble metal.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6243 - Pontic - porcelain fused to titanium and titanium alloys. D6245 - Pontic - porcelain/ceramic.		
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis. D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	50%	50%
The following services are limited to one time every 60 months. D6740 - Retainer crown - porcelain/ceramic. D6750 - Retainer crown - porcelain fused to high noble metal. D6751 - Retainer crown - porcelain fused to predominately base metal. D6752 - Retainer crown - porcelain fused to noble metal. D6753 - Retainer crown - porcelain fused to titanium and titanium alloys. D6780 - Retainer crown - 3/4 cast high noble metal. D6781 - Retainer crown - 3/4 cast predominately base metal. D6782 - Retainer crown - 3/4 cast noble metal. D6783 - Retainer crown - 3/4 porcelain/ceramic. D6784 - Retainer crown - 3/4 titanium and titanium alloys.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6790 - Retainer crown - full cast high noble metal. D6791 - Retainer crown - full cast predominately base metal. D6792 - Retainer crown - full cast noble metal.		
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond FPD.	50%	50%
The following services are not subject to a frequency limit. D6980 - FPD repair necessitated by restorative material failure.	50%	50%
Oral Surgery - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root.	20%	40%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated. D7220 - Removal of impacted tooth - soft tissue. D7230 - Removal of impacted tooth - partially bony. D7240 - Removal of impacted tooth - completely bony.	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D7241 - Removal of impacted tooth - completely bony with unusual surgical complications. D7250 - Surgical removal or residual tooth roots. D7251 - Coronectomy - intentional partial tooth removal.		
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	20%	40%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth.	20%	40%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant.	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is not subject to a frequency limit. D7471 - removal of lateral exostosis (maxilla or mandible).	20%	40%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess, intraoral soft tissue. D7910 - Suture of recent small wounds up to 5 cm. D7953 - Bone replacement graft for ridge preservation - per site. D7961 - Buccal/labial frenectomy (frenulectomy). D7962 - Lingual frenectomy (frenulectomy). D7971 - Excision of pericoronal gingiva.	20%	40%
Adjunctive Services - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure.	20%	40%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes. D9223 - Deep sedation/general anesthesia - each 15 minute	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
increment. D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. D9610 - Therapeutic parenteral drug single administration.		
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	20%	40%
The following is limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch. D9945 - Occlusal guard - soft appliance, full arch. D9946 - Occlusal guard - hard appliance, partial arch.	20%	40%
Implant Procedures - Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant. D6012 - Surgical placement of interim implant body. D6040 - Surgical placement of eposteal implant. D6050 - Surgical placement: transosteal implant. D6055 - Connecting bar - implant supported or abutment supported.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6056 - Prefabricated abutment - includes modification and placement. D6057 - Custom fabricated abutment - includes placement. D6058 - Abutment supported porcelain/ceramic crown. D6059 - Abutment supported porcelain fused to metal crown (high noble metal). D6060 - Abutment supported porcelain fused to metal crown (predominately base metal). D6061 - Abutment supported porcelain fused to metal crown (noble metal). D6062 - Abutment supported cast metal crown (high noble metal). D6063 - Abutment supported cast metal crown (predominately base metal). D6064 - Abutment supported cast metal crown (noble metal). D6065 - Implant supported porcelain/ceramic crown. D6066 - Implant supported crown - porcelain fused to high noble alloys. D6067 - Implant supported crown - high noble alloys. D6068 - Abutment supported retainer for porcelain/ceramic FPD. D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal). D6070 - Abutment supported retainer for porcelain fused to metal		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
FPD (predominately base metal). D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal). D6072 - Abutment supported retainer for cast metal FPD (high noble metal). D6073 - Abutment supported retainer for cast metal FPD (predominately base metal). D6074 - Abutment supported retainer for cast metal FPD (noble metal). D6075 - Implant supported retainer for ceramic FPD. D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys. D6077 - Implant supported retainer for metal FPD - high noble alloys. D6080 - Implant maintenance procedure. D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure. D6082 - Implant supported crown - porcelain fused to predominantly base alloys. D6083 - Implant supported crown - porcelain fused to noble alloys. D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys. D6086 - Implant supported crown - predominantly base alloys.		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6087 - Implant supported crown - noble alloys. D6088 - Implant supported crown - titanium and titanium alloys. D6090 - Repair implant supported prosthesis, by report. D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment. D6095 - Repair implant abutment, by report. D6096 - Remove broken implant retaining screw. D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys. D6098 - Implant supported retainer - porcelain fused to predominantly base alloys. D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys. D6100 - Surgical removal of implant body. D6101 - Debridement peri-implant defect. D6102 - Debridement and osseous contouring of a peri-implant defect. D6103 - Bone graft for repair peri-implant defect. D6104 - Bone graft at time of implant replacement. D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular.		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary. D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys. D6121 - Implant supported retainer for metal FPD - predominantly base alloys. D6122 - Implant supported retainer for metal FPD - noble alloys. D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys. D6190 - Radiographic/surgical implant index, by report. D6191 - Semi-precision abutment - placement. D6192 - Semi-precision attachment - placement. D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys.		

Medically Necessary Orthodontics - Out-of-Network (Subject to payment of the Annual Deductible.)

Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, *Crouzon's Syndrome, Treacher-Coll ins Syndrome, Pierre-Robin Syndrome,* hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint *(TMJ)* conditions and/or having horizontal/ver tical (overjet/overbite) discrepancies.

All orthodontic treatment must be prior authorized.

Benefits will be paid in equal monthly installments over the course of the entire orthodonti c treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.

Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition. D8020 - Limited orthodontic treatment of the transitional dentition. D8030 - Limited orthodontic treatment of the adolescent dentition. D8070 - Comprehensive orthodontic treatment of the transitional dentition. D8080 - Comprehensive orthodontic treatment of the adolescent dentition. D8210 - Removable appliance therapy. D8220 - Fixed appliance therapy. D8660 - Pre-orthodontic treatment visit. D8670 - Periodic orthodontic treatment visit. D8680 - Orthodontic retention. D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment. D8696 - Repair of orthodontic appliance - maxillary. D8697 - Repair of orthodontic appliance - mandibular.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D8698 - Re-cement or re-bond fixed retainer - maxillary. D8699 - Re-cement or re-bond fixed retainer - mandibular. D8701 - Repair of fixed retainer, includes reattachment - maxillary. D8702 - Repair of fixed retainer, includes reattachment - mandibular.		

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Pediatric Dental Services.*
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly related with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics.* The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13. Services related to the temporomandibular joint *(TMJ),* either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this Rider to the Policy.
16. Dental Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy ends.
17. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion *(VDO).*
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Section 4: Claims for Pediatric Dental Services

When receiving Dental Services from an out-of-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information shown below.

Reimbursement for Dental Services

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

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

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

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

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

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

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

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

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

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

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

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our

reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that we accept.

Pediatric Vision Care Services Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

This Rider to the Policy provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Massachusetts Health Connector.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Policy* in *Section 8: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Policy* in *Section 8: Defined Terms.*

Jessica Paik, President

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

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

Annual Deductible

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

What Are the Benefit Descriptions?

Benefits

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

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

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-payments and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Routine Vision Exam

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

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).

- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

Eyeglass Lenses

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

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

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

Eyeglass Frames

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

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

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

Contact Lenses

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

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

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

Necessary Contact Lenses

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

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

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

Low Vision

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

Benefits include:

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

Schedule of Benefits

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Routine Vision Exam or Refraction only in lieu of a complete exam	Once every 12 months.	$30 per exam. Not subject to payment of the Annual Deductible.	20% of the billed charge.
Eyeglass Lenses	Once every 12 months.		
• Single Vision		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Bifocal		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Trifocal		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Lenticular		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Lens Extras			
• Polycarbonate lenses	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None
• Standard scratch-resistant coating	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None
• Blended Segment Lenses • Intermediate Vision Lenses • Standard Progressives • Premium Progressives • Photochromic Glass Lenses • Plastic Photosensitive Lenses • Polarized Lenses • Hi-index Lenses • Standard Anti-Reflective Coating • Premium Anti-Reflective Coating		80% of the billed charge.	80% of the billed charge.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
• Ultra Anti-Reflective Coating • Ultraviolet Protective Coating • Tinted Lenses • Oversized Lenses			
Eyeglass Frames	Once every 12 months.		
• Eyeglass frames with a retail cost up to $130.		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - 160.		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - 200.		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Contact Lenses Fitting, Evaluation and Follow-Up Care			
• Contact Lenses Fitting, Evaluation and Follow-Up Care	Once every 12 months	None Not subject to payment of the Annual Deductible.	None
• Covered Contact Lens Selection	Limited to a 12 month supply.	50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
Necessary Contact Lenses	Limited to a 12 month supply.	50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months		
• Low vision testing		None Not subject to payment of the Annual Deductible.	20% of billed charges

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
• Low vision therapy		25% of billed charges Not subject to payment of the Annual Deductible.	25% of billed charges
• Follow-up care	Four visits in any five-year period	50% of billed charges Not subject to payment of the Annual Deductible.	50% of billed charges

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Pediatric Vision Care Services,* Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for Pediatric Vision Care Services.*
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Vision Care Services

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

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

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the *Policy:*

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

UnitedHealthcare Vision Network - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the *Policy.*

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this Rider in *Section 1: Benefits for Pediatric Vision Care Services.*

Virtual Behavioral Health Therapy and Coaching Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for specialized virtual behavioral health care provided by AbleTo, Inc. for Covered Persons with certain co-occurring behavioral and medical conditions.

Because this Rider 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* in *Section 9: Defined Terms.*

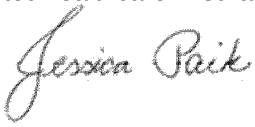
AbleTo provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for Covered Persons with a high deductible health plan (HDHP) compatible with a Health Savings Account (HSA), there are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Except for the initial consultation, Covered Persons with an HSA-compatible high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Co-payments or Co-insurance for the initial consultation.

If you would like information regarding these services, you may call us at the telephone number on your ID card.

UnitedHealthcare Insurance Company



Jessica Paik, President

Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides a Covered Person with a travel and lodging allowance related to the Covered Health Care Service provided by a Network provider that is not available in the Covered Person's state of residence due to law or regulation when such services are received in another state, as legally permissible.

Because this Rider 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 *Policy* in *Section 8: 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 that term is defined in *Section 8: Defined Terms.*

Travel and Lodging Program

The *Travel and Lodging Program* provides support for the Covered Person under the Policy as described above. The program provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Care Service.

This program provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year will be provided for travel and lodging expenses incurred as a part of the Covered Health Care Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding the *Travel and Lodging Program*, you may contact us at www.myuhc. com or the telephone number on your identification (ID) card.

UnitedHealthcare Insurance Company

Jessica Paik, President

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the 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 Policy in *Section 8: 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 *Policy* in *Section 8: Defined Terms.*

NOTE: The Coordination of Benefits provision in the *Policy* in *Section 9: 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 *Policy.*

Jessica Paik, President

Introduction

Coverage Policies and Guidelines

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

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

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen 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 you is a determination that is made by you and your prescribing Physician.

- Coverage for prescription contraceptive drugs approved by the Food and Drug Administration. Benefits defined under the Health Resources and Services Administration (HRSA) requirement include, but may be limited to the full range of FDA approved contraceptive methods without cost sharing. Benefits include at least one form of contraception in each of the methods (currently 18) that the FDA has identified in its current Birth Control Guide. These methods are including, but not limited to, hormonal methods, such as oral contraceptives, and oral medications for emergency contraception.
- Benefits for Prescription Drug Products are available for pharmacotherapy when prescribed by a Physician for tobacco cessation treatment and are limited to:
- Two 90-day courses of pharmacotherapy per Covered Person per year.
- Initiation of any course of pharmacotherapy will be considered an entire course of pharmacotherapy, even if a Covered Person discontinues or fails to complete the course.
- For the purposes of this Rider, "pharmacotherapy" means the use of first-line drugs, approved by the U.S. Food and Drug Administration (FDA) and available by prescription only, to assist in the cessation of tobacco use or smoking.
- Benefits for pharmacotherapy for tobacco cessation treatment are subject to all applicable requirements of this Rider.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, 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 contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim.* When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription

Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at www.myuhc.com or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid.

If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Pharmacy Co-payment and/or Co-insurance.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program,* by contacting us at www.myuhc.com or the telephone number on your ID card.

Smart Fill Program - 90 Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Co-payment and/or Co-insurance will reflect the number of days dispensed. The *Smart Fill Program* offers a 90-day supply of certain Specialty Prescription Drug Products if you are stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program.* You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program,* by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with 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 or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Variable Co-payment Program

Certain Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceuti cal manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Specialty Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary. Please contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits.*

The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.

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 taking part in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc. com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at a Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at www.myuhc.com or 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 either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception; provide hormone replacement therapy for peri and post-menopausal women; or orally administered anticancer medication used to kill or slow the growth of cancerous cells.

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 have informed us of your decision not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, and you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

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

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

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

Prescription Drugs from a Retail Out-of-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your Policy in *Section 5: How to File a Claim.* We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are

provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the Policy also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum 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 treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
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 Policy. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to 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.
    - Single entity vitamins.
12. Certain unit dose packaging or repackagers 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 Care Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.

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 contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 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 made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.

19. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on 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, and prescription medical food products even when used for the treatment of Sickness or Injury, except for Prescription Drug Products that are the following, as described in the Policy *Section 1: Covered Health Care Services, Enteral Nutrition:*

    - Non-prescription enteral formulas for home use when ordered by a Physician for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids.
    - Food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acids.
    - Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria when prescribed by a Physician.

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. 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. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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

25. Certain Prescription Drug Products that have not been prescribed by a Specialist.

26. A Prescription Drug Product that contains marijuana, including medical marijuana.

27. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

28. Dental products, including but not limited to prescription fluoride topicals.

29. A Prescription Drug Product with either:

- An approved biosimilar.
- A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Diagnostic kits and products, including associated services.
31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
32. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

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

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

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

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

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

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

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

Infertility - Have been unable to conceive or produce conception after one year if the woman is under age 35, or after six months, if the woman is over age 35. For the purposes of meeting these criteria, if a woman conceived but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy will be included in the calculation of the year or six month period, as applicable.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

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 placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, 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 find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

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

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA).* This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally 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 and insulin pens.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;

- blood glucose monitors;
- prescribed oral diabetes medication that influence blood sugar levels; and
- glucose meters, including continuous glucose monitors.

- A drug which has been prescribed for treatment of cancer or HIV/AIDS treatment even if the drug has not been approved by the FDA for that indication, if the drug is recognized for the treatment of that indication:
  - In one of the following established reference compendia:
    - The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI);
    - The American Medical Association's Drug Evaluations (AMADE);
    - The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHES-DI); or
    - For off-label uses of prescription drugs for the treatment of cancer only, the Association of Community Cancer Centers' Compendia-Based Drug Bulletin.
  - Scientific studies in any peer-reviewed national professional journal.
  - By the commissioner of the Massachusetts Division of Insurance.
  - However, there is no coverage for any drug when the FDA has determined its use to be contraindicated.

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

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate under Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.* Specialty Prescription Drug Products include certain drugs for Infertility and may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or 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. This fee includes any applicable dispensing fee and sales tax.

Section 4: Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the *Benefit Information* table in the *Outpatient Prescription Drug Schedule of Benefits,* in addition to any applicable Ancillary Charge.

Urgent Requests

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

External Review

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

Expedited External Review

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

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

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

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment and/or Co-insurance may change

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product. and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

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

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

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

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.co m or 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. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim.*

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

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

What Do You Pay?

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.

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

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

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

- Ancillary Charges.
- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.

- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in 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 these programs and any applicable prior authorization, participation or activation requirements	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Variable Co-payment Program:** Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Prescription Drug Products and the applicable Co-payment and/or Co-insurance. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly	

Payment Term And Description	Amounts
but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
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, or as allowed under the Smart Fill Program. 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 Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. We designate certain Network Pharmacies to be Preferred Specialty Network Pharmacies. We may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to you unless required by law. You may determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy by contacting us at www.myuhc.com or by the telephone number on your ID card. If you choose to obtain your Specialty Prescription Drug Product from a Non-Preferred Specialty Network Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Preferred Specialty Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $60 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill. ***Non-Preferred Specialty Network Pharmacy*** You will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Out-of-Network Reimbursement Rate after you pay $5 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	For a Tier 2 Specialty Prescription Drug Product: $60 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Out-of-Network Reimbursement Rate after you pay $5 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: None of the Out-of-Network Reimbursement Rate after you pay $5 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 Co-payment and/or Co-insurance 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 Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $60 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Prescription Drugs from a Retail Out-of-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 Co-payment and/or Co-insurance 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 Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: None of the Out-of-Network Reimbursement Rate after you pay $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $60 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: None of the Out-of-Network Reimbursement Rate after you pay $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: None of the Out-of-Network Reimbursement Rate after you pay $5 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail 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	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Specialty Prescription Drug Products. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. 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 Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	$5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $60 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $5 per Prescription Order or Refill. For up to a 60-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $60 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $120 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $270 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For up to a 90-day supply at a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $60 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $120 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
	For a Tier 2 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $270 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill.

Zero Cost Share Medications Addendum

UnitedHealthcare Insurance Company

As described in this addendum, certain Prescription Drug Products as 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 *Policy* in *Section 8: Defined Terms,* in the *Outpatient Prescription Drug Rider* in *Section 3: Defined Terms,* and in this addendum below.

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 *Policy* in *Section 8: Defined Terms.*

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

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

The following definition is added to *Section 3: Defined Terms* in the *Outpatient Prescription Drug Rider:*

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

UnitedHealthcare Insurance Company

Jessica Paik, President