

Member Service Request Form Instructions

At UnitedHealthcare, we continuously strive to bring you a higher level of service. Although you are not required to submit this form, completing it will help us address your issue in a timely and thorough manner.

When should I use this form?

You may use this form to submit:

- information requested by UnitedHealthcare
- a question about a claim or your coverage
- a formal review of or a complaint regarding a claim, coverage determination or service received

How do I submit a request?

Please complete the attached form as follows:

Section I: Your information

- Enter the information specific to yourself, as the person completing the form. You may or may not be the person who received medical services. Please remember to also have the patient complete the *Authorization For The Use and Disclosure of Information* form if you are not the patient, enrollee, parent/legal guardian, or provider of service. This form can be obtained from your member website, **myuhc.com®**, under the link "Claims and Accounts." In some circumstances, state law requires that this form be completed if you are not the patient. We will notify you if your submission requires the completion of this Authorization Form.

Section II: Information from your plan's explanation of benefits, health statement or medical ID card

- The items to be completed in this section can be found on your plan's explanation of benefits (EOB) or health statement received from UnitedHealthcare after your claim was processed or from your health plan ID card.
- The subscriber ID is a nine-digit number.
- The group number is a five- to seven-character number.
- Demographic information such as your address cannot be updated by submitting this form. Please contact your employer with any updates to this information.

Section III: Reason for request

- Check the box that best describes your reason for the submission.
- If you are requesting a formal review of a decision made by UnitedHealthcare regarding the handling of a claim or coverage for a health service, please include additional comments to explain your request or situation. You may attach additional pages as necessary. **Please do not write on the back of the form.**

Section IV: Submitting your request

- **Complete and submit only the form that appears on the following page.** Keep this instruction page for your records, as well as a copy of the completed form.
- If your request is related to the handling of a claim, attach a copy of your health statement or EOB for each claim, if available. You may obtain a copy of your EOBs on **www.myuhc.com**.
- If you are submitting additional information requested by UnitedHealthcare, please attach a copy of the letter received requesting this information, if available.
- If you have other documentation or items that may help us understand your request or better explain your situation, please attach these items also.
- If your group number, which is listed on your medical ID card, is **192744, 194422, 197313, 229050, 393476, 401010, 503777, 700406, 707997, 722266, 722267, 722268, 722269, 722270 or 722271**, mail the form with any attachments to:
**UnitedHealthcare Member Inquiry/Appeals
PO Box 740816 Atlanta, GA 30374-0816.**
- Mail the form with any related attachments to:
**UnitedHealthcare Member Inquiry/Appeals
PO Box 30432 Salt Lake City, UT 84130-0432.**
- Upon receipt of this form and any supporting documentation, we will send you a written response within the time frame required by your state or employer, but no later than 45 days from receipt of necessary information.



Member Service Request Form

Date form completed: / /

SECTION I: Your information

Name of person completing this form: Last First MI

Address: _____

City: State: ZIP: Telephone () Ext:

What is your relationship to the patient?

☐ Subscriber ☐ Parent/Legal Guardian ☐ Provider of Service ☐ Other** _____

***If "other" is checked, please print and have the patient complete the form titled Authorization For The Use and Disclosure of Information and attach it to your request.*

SECTION II: Information from your explanation of benefits, health statement or ID card

Subscriber ID number (nine-digit number): Group/Contract # (five to seven digits)

Member (subscriber) name: Last First MI

Patient name: Last First MI

Patient's date of birth: / /

Address: City State: ZIP:

Date of service: / / Total amount charged: \$ (required only if your request is about a claim)

Provider of medical services (as listed on your explanation of benefits or health statement):

SECTION III: Reason for request

☐ I am submitting the additional information requested by UnitedHealthcare. This may include coordination of benefits, full-time student status information, medical records, accident information or other requested information. (Please attach the requested documents along with the letter you received requesting this information, if available.)

☐ I have a question about how a claim was processed, my benefits or available coverage, requirements of my plan, or some other issue. (Please explain below.)

☐ I am requesting a formal review of a decision made by UnitedHealthcare regarding the handling of a claim or coverage for a health service, or I have a complaint regarding a claim, coverage determination or service received. (Please explain below.)

Additional comments: (Required if boxes 2 or 3 are checked above. Attach additional pages if necessary.)

Please do not write on the back of this form.

SECTION IV: Submitting your request

1. Complete this form to the best of your ability. Please do **not** submit new claims to be processed.
2. Attach a copy of your health statement or explanation of benefits, if available, as well as other items that may help us understand your request.
3. Mail this form along with attachments to the PO Box indicated for your group number on the instruction page.



Using your pharmacy benefits

Optum Rx® is your plan's pharmacy services manager and is committed to helping you find cost-effective ways to get your medications.

Set up your online account

Once registered on myuhc.com®, access the pharmacy section to:

- Manage your home delivery medications
- Set up email or text message¹ reminders
- Check your home delivery status

Use the UnitedHealthcare app

Manage your prescription benefit and home delivery orders with the UnitedHealthcare® app on your smartphone or tablet.

Use a network pharmacy

Be sure to fill your prescriptions at a network pharmacy, otherwise they may not be covered or you may pay more.² Finding a network pharmacy is easy:

- Log in to myuhc.com
- Or use the UnitedHealthcare app
- Or call the number on your health plan ID card

**United
Healthcare**

Home delivery from Optum

Consider using Optum® Home Delivery to help manage the medications you take regularly. Home delivery is reliable and offers the following advantages:



Cost savings

You may pay less for your medication with a 3-month supply.



Convenience

Get free standard shipping.



24/7 access and reminders

Speak to a pharmacist any time, any day. Set up medication reminders.

You may be able to refill your home delivery prescriptions automatically through the Automatic Refill program.

If you need your medication right away, ask your doctor for a 1-month prescription to fill at a local pharmacy and a 3-month prescription you can use to set up home delivery.

How to choose home delivery

By going online:

Visit myuhc.com, register and follow the simple step-by-step instructions.

By phone:

Call the member phone number on the back of your plan ID card. It's helpful to have your plan ID card and medication bottle available.

By ePrescribe:

Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe.*

*This update does not apply to providers in Alaska, Guam, Puerto Rico or the U.S. Virgin Islands.

Making medication decisions

Use the UnitedHealthcare prescription drug list (PDL)

The PDL is a list of your plan’s covered medications. The medications are organized into cost tiers. Choosing medications in lower tiers may save you money.

| Cost tier | Includes | Helpful tips |
|--------------------------------------|---|---|
| \$ Tier 1 — Lowest cost | Lower-cost medications. Some brand-name medications. | In most cases, Tier 1 medications have the lowest cost. Consider generic options which may also help you save. |
| \$ Tier 2 — Mid-range cost | Mix of brand-name and generic medications. | Tier 2 drugs may cost less than Tier 3 drugs. ³ |
| \$ Tier 3 — Highest cost | Highest-cost brand-name medications and some generic medications. | Many Tier 3 medications have lower-cost options in Tiers 1 or 2. Ask your doctor if they could work for you. ³ |

*Some Connecticut plans have a 4th tier that includes higher cost brand-name and generic medications, as well as non-preferred brand-name and specialty medications.

Save money

In most cases, generic medications have a lower copay than brand-name medications. Ask your doctor if there is a generic alternative for you.

Compare prices

Search for lower-cost alternatives. Just log in to myuhc.com. Or use the UnitedHealthcare app.



Tips



Know your plan

Your plan may require one or more of the following for your prescription to be covered:

Prior authorization: approval to get a medication.

Step therapy (First Start for NJ plans only): trying one medication before another.

Quantity limits: only a certain amount of the medication is allowed for coverage.

Log on to myuhc.com to see if you could save. Or use the UnitedHealthcare app.



Talk to your doctor

When you talk with your doctor, use the UnitedHealthcare app to confirm coverage and costs. You can also talk about what you need to do to get your medication.



Optum Specialty Pharmacy

At Optum® Specialty Pharmacy, we offer the resources, programs and clinical support you need to manage your specialty medications with confidence.

Your plan may also include

Your plan **may include** the cost-saving medication home delivery program below. With each of these programs, you are allowed a limited number of refills at your current pharmacy. Then you must take action.

Mail Service Saver

Switch to Optum Home Delivery or you may pay more.

Mail Service Saver Plus

Switch to Optum Home Delivery or you will pay the full price for your medication.

Nondiscrimination notice and access to communication services

UnitedHealthcare® does not discriminate on the basis of race, color, national origin, age, disability, or sex in its health programs or activities.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: **Civil Rights Coordinator.**

UnitedHealthcare Civil Rights Grievance.

P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, **TTY 711**, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at

<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free **1-800-368-1019, 800-537-7697 (TDD)**

Mail: **U.S. Dept. of Health and Human Services.**

200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card **TTY 711**, Monday through Friday, 8 a.m. to 8 p.m.

Multi-language interpreter services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, नशिल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEBOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ផ្សាយព័ត៌មាន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សម្រាប់ការសម្របសម្រួលសេវាជំនួយភាសា ឬសេវាផ្សេងៗទៀត គឺមានសេវាឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដើម្បីទទួលបានលេខសេវាឥតគិតថ្លៃសេវាឥតគិតថ្លៃ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguaghe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

Díí BAA'ÁKONINÍZIN: **Diné (Navajo)** bizaad bee yániit'ígo, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'hóót'í. T'áá shq'qí ninaaltsoos nít'ízi bee nééhozinígíí bine'déé' t'áá jík'ehgo béesh bee hane'í biká'ígíí bee hodílini.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.



Questions? Visit myuhc.com to learn more.

United Healthcare

¹ Optum Rx provides this service at no cost. Standard message and data rates charged by your carrier may apply.

² In New York, prescriptions filled at an out-of-network pharmacy may not be covered. In New Jersey, you may need to pay more for prescriptions filled at an out-of-network pharmacy.

³ For New Jersey plans, generic drugs will not exceed \$25 for a 30-day supply, preferred drugs will not exceed \$50 for a 30-day supply, and non-preferred drugs will not exceed \$75 for a 30-day supply.

Optum Home Delivery is a service of OptumRx.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health plan coverage provided by or through a UnitedHealthcare company. Optum Rx, Inc. is an affiliate of UnitedHealthcare Insurance Company.

Optum Rx and Optum Specialty Pharmacy are subsidiaries of UnitedHealth Group. UnitedHealthcare and the dimensional U logo are trademarks of UnitedHealth Group Incorporated. All other trademarks are the property of their respective owners.

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Important things to know about selecting your PCP

A primary care provider (PCP) is your health guide—someone who can help coordinate your care and supports you in achieving your best health.

Your PCP:

- Must be a general practice, family practice, pediatrician or internal medicine provider*
- Must be an individual provider, not a medical practice**
- Must be accepting new patients (if you are not a current patient)
- Must be located in a town or city near where you (the subscriber) live or work
- Can be selected for the entire family or each covered member can select their own



A PCP is the doctor who knows you best—who understands your health history and health goals. They're who you turn to first—for everything from routine care to prescriptions and more.

And, since most PCPs offer virtual visits for primary care, you can choose to see them in person or from home.

So, whether or not your plan requires you to have a PCP, it's a good idea to choose one.

See reverse side for instructions on how to select a PCP.

*Some states allow you to choose a specialist, like an OB/GYN, as your PCP. Contact your employer for more information.

**Some health plans may allow you to choose a medical group rather than a doctor as your PCP.

continued

Follow these steps to choose your PCP

- 1 • Go to myuhc.com® (you don't need to sign in)

• Then select **Find a Provider > Medical Directory** then, **Employer and Individual Plans**.

Not sure which plan name to look for? Check your open enrollment materials or ask your employer.
- 2 If prompted, select the year in which you will be receiving care (choose the following year if you are making open enrollment selections)—confirm the ZIP code for your search, choose **People**, then **Primary Care**, then select from any of the categories listed.

John Smith, MD
Family Practice
★★★★★ (27)
In-Network

OVERVIEW SERVICES & COSTS LOCATIONS PATIENT REVIEWS

2 Locations for 12345

ADJUST RADIUS
Within 20 Miles

| Location | Phone | Availability | Additional Information |
|--|---|--|--|
| 1234 Main Street, Ste 123 Anytown, ST 12345 4 Miles Away Get Directions View Hours > OPEN NOW | (555) 555-1234 Phone 123 TTY Website Not Available Email Not Available | Evening Appointments Weekend Appointments Accessibility Parking > Patient Age & Gender Requirements 0 - 150 years | Premium Care Physician Accepting All Patients Provider ID 01234567891234 Copy |
| 1010 North Hwy, Ste 100 Othertown, ST 12345 7 Miles Away Get Directions View Hours > OPEN NOW | (555) 555-5555 Phone 456 TTY Website Not Available Email Not Available | Evening Appointments Weekend Appointments Accessibility Parking > Patient Age & Gender Requirements 0 - 150 years | Premium Care Physician Accepting All Patients Provider ID 43219876543210 Copy |

3 Scroll through the search results, and once you have made your selection, click on the provider's name to **locate the Provider ID in the lower right corner of the page**. Select **Copy** or write it down—you'll need it when you enroll.

4 If your selected PCP is associated with multiple locations, you can find the correct Provider ID by selecting **Locations** and then copying the appropriate Provider ID.

And there you have it—choosing your PCP is the first step in the process to help manage your health. Be sure to schedule your first visit with your PCP. It can be a great way for your doctor to get to know you—and vice versa.

Questions?

For enrollment support please call **1-866-873-3903** or visit www.myuhc.com

United Healthcare

This Guide is intended for individuals selecting a new plan (or) in open enrollment. Active members should log in to myuhc.com for assistance.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

UnitedHealthcare Level Funded: Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

Stop Loss only: Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company of New York (in NY) and UnitedHealthcare Insurance Company (in all other states and DC).

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to myuhc.com, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to myuhc.com or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.



UnitedHealthcare Insurance Company
UnitedHealthcare Open Access POS - INN and OON
Certificate of Coverage, Riders, Amendments, and
Notices

for

HRI Properties, LLC

Group Number: 1700220

Health Plan: F9000

Prescription Code: Surest_LA_2024_RX_ALT_3

Effective Date: January 1, 2025

Offered and Underwritten by UnitedHealthcare Insurance Company

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate*, the Policy includes:

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders, including the *Outpatient Prescription Drug Rider*.
- Amendments.

You can review the Section 5: How to File A Claim at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens, we will send you a new *Certificate*, Rider, or Amendment.

Other Information You Should Have

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

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

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Louisiana. The Policy is subject to the laws of the state of Louisiana and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Louisiana law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: 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 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at benefits.surest.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

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

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

How Do You Contact Us?

You may visit benefits.surest.com or call Surest Member Services at 866-683-6440. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Eligibility, Enrollment, and Required Contributions

Benefits are available to you once you are enrolled for coverage under the Policy. The Group will apply the eligibility rules.

- Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:
 - Your enrollment must be in accordance with the rules of the Policy issued to your Group, including the eligibility rules.
 - You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.
- You continue to receive Benefits as long as you continue to qualify as a Subscriber or Dependent as defined in *Section 9: Defined Terms* and meet the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application*.
- Your Benefits are no longer available as described in *Section 4: When Coverage Ends*.

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

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable Co-payment for Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable Co-payment amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

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

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

Subject to *Section 6: Questions, Complaints and Appeals*, we have the discretionary authority to do the following:

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

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

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

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

Pay Network Providers

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

Pay for Covered Health Care Services Provided by Out-of-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We adjudicate claims consistent with industry standards. We develop our reimbursement policy guidelines, as we determine, generally in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and

providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by visiting benefits.surest.com or calling the telephone number on your ID card.

Offer Health Education Services to You

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

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility rules specified in the Policy which includes this *Certificate* and the *Group Application*.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

Benefits are provided for services delivered via Telehealth. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

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

- The amount you must pay for these Covered Health Care Services (including any Co-payment).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

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

How Does Your Policy Work?

This Policy is designed to help you make informed choices about your health care, costs, and coverage needs. With the Surest mobile application and the benefits.surest.com website, you can search for available care, cost, and coverage options in advance from any geographic location to choose the best option for you. You can also call the telephone number on your ID card for assistance with navigating your coverage options.

Your Policy has no deductible or co-insurance; however, Co-payments are required for Covered Health Care Services.

By using the Surest mobile app or the benefits.surest.com website, you can search not only for a provider, but also by condition. Depending on the type of condition you enter into the search, the results will provide Covered Health Care Services information and other treatment options for you to consider and discuss with your Physician for the type of treatment you are searching for, such as office visits, rehabilitation services, complex imaging, as well as associated costs with each service. Please note that

the Surest mobile app or the benefits.surest.com website does not currently display other treatment options for every condition.

1. Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

2. Ambulance Services

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

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Transportation by professional ambulance services, including air or surface transport, of all the newly born to the nearest available hospital or neonatal special care unit for treatment of illnesses, injuries, congenital defects, and complications of premature birth but the coverage need not include transportation services for the purpose of obtaining routine well baby care.

3. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

4. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.

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

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - The clinically appropriate monitoring of the effects of the service or item, or
 - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to therapeutic or palliative intent for Covered Persons with cancer, for the prevention or early detection of cancer, or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.

- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- A federally funded general clinical research center.
- The *Coalition of National Cancer Cooperative Groups*.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ♦ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
 - (a) One of the United States NIH.
 - (b) A cooperative group funded by one of the NIH.
 - (c) The FDA in the form of an investigational new drug application.
 - (d) The United States Department of Veterans Affairs.
 - (e) The United States Department of Defense.
 - (f) A federally funded general clinical research center.
 - (g) The Coalition of National Cancer Cooperative Groups.
- The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
- Facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training. They must be capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.
- There must be no clearly superior, non-investigational approach.
- The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.
- The Covered Person has signed an *IRB* approved consent form.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

5. Dental Services - Accident and Medical

Accident Only

Dental services when both of the following are true:

- Treatment is needed because of accidental damage.

- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

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

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

Medical Only

Dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Services for general anesthesia and associated Hospital or Alternate Facility charges, when the dentist and Physician determine that services are necessary for a Covered Person who: a) is a child under age five, b) is severely disabled, or, c) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment.

Oral Surgery

Removal of erupted or impacted teeth.

6. Diabetes Services

For the purpose of this section diabetes includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes.

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

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

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies and Prosthetic Services*. Benefits for blood glucose meters including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.

7. Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies, and Prosthetic Services

Benefits are provided for DME, external prosthetic devices, and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.
- Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain *U.S. Food and Drug Administration (FDA)* approved over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- ♦ A medical exam.

- ♦ A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- ♦ A written prescription or other order.

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

- ♦ Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- ♦ Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

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

Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Scalp/cranial hair prostheses (wigs) for scalp/head wound, burns, Injury, and alopecia areata, cancer, and undergoing chemotherapy or radiation therapy.

Benefits include breast prosthesis, mastectomy bras and lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Benefits as specified in this section will be available for the purchase of orthotic devices authorized by us. These Benefits will be subject to the following:

- Orthotic devices must function as rigid or semi-rigid supportive devices restricting or eliminating motion of a weak or diseased body part.
- Not consumable or disposable except as needed for the effective use of covered orthotics.
- No coverage for fitting or adjustments.
- No coverage for supportive devices for the foot, except when used in the treatment of diabetic foot disease.
- Benefits covering standard devices will be provided toward any deluxe device when you select a deluxe device solely for comfort or convenience. Benefits for deluxe devices based on allowed coverage for deluxe devices will only be provided when documented to be Medically Necessary.
- If more than one piece of orthotic devices can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Prosthetic Services are covered and means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It shall also include and Medically Necessary clinical care.

We will decide if the equipment should be purchased or rented. If the equipment is rented, the Co-payment may be split over the rental period, at which point the item may be purchased.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment* and under *Devices, Appliances and Prosthetics*.

These Benefits apply to external DME and prosthetic devices. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

DME, orthotics, prosthetic devices and supplies are assigned to tiers. To determine the tiers to which DME, orthotics, prosthetic devices, and supplies are assigned, visit benefits.surest.com or call the telephone number on your ID card. This list is subject to periodic review and modification (generally quarterly, but not more than six times per year).

8. Emergency Health Care Services - Outpatient

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

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

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding as the primary source of nutrition, for certain conditions under the direction of a Physician.

When prescribed by a Physician or licensed pediatric provider, Benefits are also provided for Medically Necessary pasteurized donor human milk for infants that are medically or physically unable to receive maternal human milk or participate in breastfeeding, or the infant's mother is medically or physically unable to produce human milk in sufficient quantities for up to two months.

10. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under your *Outpatient Prescription Drug Rider* or under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

12. Habilitative Services

Health care services and devices that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

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

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

- Treatment is administered by any of the following:
 - Licensed speech-language pathologist.
 - Licensed audiologist.
 - Licensed occupational therapist.
 - Licensed physical therapist.
 - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Educational/Vocational training.
- Residential Treatment.
- A service or treatment plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Medical records.
- Other necessary data to allow us to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress.

Habilitative services provided in your home are provided as described under *Home Health Care*.

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

Outpatient habilitative services for occupational therapy, physical therapy and speech therapy for the treatment of Mental Illness are provided under *Mental Health Care and Substance-Related and Addictive Disorders Services*.

13. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

14. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can visit benefits.surest.com or call the telephone number on your ID card for information about our guidelines for hospice care.

15. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

Coverage includes services for advanced molecular techniques including but not limited to traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening that include individual sequencing, trio sequencing for a parent or parents an infant, and ultra-rapid sequencing for an infant who is one year of age or younger, is receiving inpatient hospital services in an intensive care unit or in a pediatric care unit, and has a complex illness of unknown etiology.

16. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Diagnostic mammogram or breast ultrasound screening for breast cancer designed to evaluate an abnormality in the breast that is any of the following:
 - Seen or suspected from a screening examination for breast cancer;
 - Detected by another means of examination; or
 - Suspected based on the medical history or family medical history of the individual.

Benefits include Physician services, the facility charge, and the charge for supplies and equipment.

- Pre-Admission Testing.
- Medically Necessary home or laboratory sleep studies. These include only sleep studies performed in the home or sleep studies performed in a sleep laboratory that is accredited by the *Joint Commission* or the *American Academy of Sleep Medicine (AASM)*. Benefits for sleep studies will not be covered unless performed in the home or performed in a sleep laboratory that is accredited by the *Joint Commission* or *AASM*. If a sleep study is performed in a sleep laboratory that is not accredited by one of these bodies, or a sleep study is denied, then neither the sleep study nor any professional claims associated with the sleep study will be covered.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling. Limited to Genetic Testing for the following:
 - Cancer susceptibility.
 - Hereditary diseases.
 - Unspecified molecular pathology.
 - Fetal aneuploidy.
- Presumptive Drug Tests and Definitive Drug Tests.
- Genetic or Molecular Testing for cancer including but not limited to Tumor Mutation Testing, Next Generation Sequencing, Hereditary Germline Mutation Testing, Pharmacogenomic Testing, Whole Exome and Genome Sequencing, and Biomarker Testing
- With respect to men, screening for prostate cancer for all men age 40 and older.
- Bone mass measurement. Includes bone mineral density testing for the diagnosis and treatment of osteoporosis for any Covered Person who is:
 - An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment.
 - An individual receiving long term steroid therapy.
 - An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.
- Prostate cancer detection that includes a digital rectal examination and prostate-specific antigen testing for Covered Persons over the age of 50 and as appropriate for Covered Person over the age of 40. A second visit shall be permitted for follow-up treatment within 60 days after the visit if related to a condition diagnosed or treated during the visit and recommended by a Physician.

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

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment) apply, when services are provided in a Physician's office.

17. Major Diagnostic and Imaging - Outpatient

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

Benefits include Physician services, the facility charge, and the charge for supplies and equipment.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment) apply, when services are provided in a Physician's office.

18. Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or either in-person in a provider's office or through telehealth services. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure. Benefits under this section include benefits for Severe Mental Illness as required by Louisiana insurance law.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- E-Visit.
- Biofeedback.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)*) that are the following:
 - Focused on the treatment of core deficits of Autism Spectrum Disorder.
 - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
 - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate*.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care. This can be done by calling the telephone number on your ID card.

19. Palliative Care

Palliative care for Covered Persons with a new or established diagnosis of progressive debilitating Sickness.

Covered Health Care Services for hospice care provided by a licensed hospice agency are described under *Hospice Care*.

20. Pharmaceutical Products - Outpatient

Certain Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products and the administration of the Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate*. Benefits for medication normally available by a prescription or order or refill are provided as described under *Outpatient Prescription Drug Rider*.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by visiting benefits.surest.com or calling the telephone number on your ID card.

To find out which Pharmaceutical Products are covered visit benefits.surest.com or call the telephone number on your ID card.

21. Physician's Office Services - Sickness and Injury

Services provided at home, in-person in a Physician's office, or through telehealth services for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. This includes Benefits for outpatient visits to registered dietitians.

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

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include:

- Primary Care Physician and Specialist Physician office visits.
- Convenience Care Clinic (retail) visits.
- Allergy injections.
- E-Visit.
- Biofeedback.

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

22. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Benefits include those of a certified nurse-midwife.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

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

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

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

23. Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
 - Ovulation induction (or controlled ovarian stimulation).
 - Egg retrieval, fertilization and embryo culture.
 - Embryo biopsy.
 - Embryo transfer.
 - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

24. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- 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*. Benefits include genetic testing of the BRCA1 and BRCA2 genes. Benefits for colorectal cancer screenings that do not have in effect a rating of "A" or "B" are described under *Scopic Procedures – Outpatient Diagnostic and Therapeutic*. Benefits for screenings that do not have in effect a rating of "A", or "B" are described under *Lab, X-Ray and Diagnostic-Outpatient*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits include immunizations for Enrolled Dependent children from birth to age six. The immunizations will be the complete basic series as defined by the Louisiana health office and required for school entry.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
 - One routine pap smear every year.
 - Routine wellness physician examination.
 - Screening for anxiety.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by visiting benefits.surest.com or by calling the telephone number on your ID card.

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

- Which pump is the most cost effective.
 - Whether the pump should be purchased or rented (and the duration of any rental).
 - Timing of purchase or rental.
 - Benefits under this section include the following as required by Louisiana law:
- Benefits for screening mammography including but not limited to digital breast tomosynthesis (DBT):
 - One baseline mammogram from Covered Persons 35 to 39 years of age.
 - An annual mammogram (DBT preferred modality) for any woman who is 40 or older.
 - Consideration is given to women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual MRI starting at age 25 and annual mammography (DBT preferred modality) starting at age 30. Such examinations shall be in accordance with recommendations by *National Comprehensive Cancer Network* guidelines or the *American Society of Breast Surgeons Position Statement on Screening Mammography*.
 - Annual mammography (DBT preferred modality) and access to supplemental imaging (MRI preferred modality) starting at age 35 upon recommendation by her physician if the woman has a predicted lifetime risk greater than twenty percent by any validated model published in peer reviewed medical literature.
 - Benefits for prostate cancer screening include a digital rectal examination and prostate-specific antigen testing for Covered Persons over the age of 50 and as appropriate for Covered Persons over the age of 40. A second visit shall be permitted for follow-up treatment within sixty (60) days after the visit if related to a condition diagnosed or treated during the visit and recommended by a Physician.
 - Benefits for routine colorectal cancer screening. Routine colorectal cancer screening means a flexible sigmoidoscopy, colonoscopy or annual FIT (Fecal Immunochemical Test for blood) provided in accordance with the most recently published recommendations established by the *American College of Gastroenterology*, in consultation with the *American Cancer Society*, colonoscopy every 10 years beginning at age 45; Flexible Sigmoidoscopy every 5-10 years, annual FIT (Fecal Immunochemical Test for blood), CT colonography every five years or the FIT-fecal DNA test every three years or capsule colonoscopy every five years.

- Colorectal cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services*.
- Benefits for genetic or molecular cancer testing including but not limited to tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomic testing, whole exome, genome sequencing.
- Benefits include bone mineral density testing for the diagnosis and treatment of osteoporosis for any Covered Person who is:
 - An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment.
 - An individual receiving long term steroid therapy.
 - An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

25. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, including contralateral prophylactic mastectomies, whether a partial mastectomy or a full unilateral or bilateral mastectomy as chosen by the Covered Person and Physician. For purposes of this Benefit, "breast reconstruction" means all stages of reconstruction of the breast on which a mastectomy has been performed and on the other breast to produce a symmetrical appearance, including but not limited to liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future, and prostheses and physical complications, including but not limited to lymphedemas.

Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the telephone number on your ID card for more information about Benefits for mastectomy-related services.

26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

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

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

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility, including physical therapy delivered via Telehealth. Rehabilitative services provided in your home are provided as described under *Home Health Care*.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met. This determination will be based on medical necessity in conjunction with the Covered Person's treatment provider.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly.

Outpatient rehabilitation services for occupational therapy, physical therapy and speech therapy for the treatment of Mental Illness are provided under *Mental Health and Substance-Related and Addictive Disorders Services*.

27. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include Physician services, the facility charge, and the charge for supplies and equipment.

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment) apply, when services are provided in a Physician's office.

28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- Supplies and Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

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

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.

- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met. This treatment plan determination will be based on medical necessity in conjunction with the Covered Person's treatment provider.

29. Surgery - Outpatient

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

Benefits include certain scopic procedures, minor office procedures and complex office procedures.

Benefits include Physician services, the facility charge and the charge for supplies and equipment.

Second Surgical Opinions. A second opinion is not mandatory in order to receive Benefits. A Second opinion consultant:

- Must not be the Physician who first recommended elective surgery.
- Must be a Specialist for the Injury or Sickness.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment) apply, when services are provided in a Physician's office.

30. Joint (TMJ) Services and Orthognathic Surgery

Services for the evaluation and treatment of TMJ and associated muscles.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include *FDA* -approved TMJ prosthetic replacements when all other treatment has failed.

Benefits are also provided for orthognathic surgery.

31. Therapeutic Treatments - Outpatient

Therapeutic treatments received at home (dialysis) or on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office, including:

- Apheresis.
- Dialysis (both hemodialysis and peritoneal dialysis).
- Hyperbaric oxygen therapy.
- Intravenous chemotherapy.
- Radiation oncology.
- Blood transfusions.
- Non-oral radiopharmaceutical therapy.
- Oral radiopharmaceutical therapy.

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

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include Physician fees, the facility charge and the charge for related supplies and equipment.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment) apply, when services are provided in a Physician's office.

32. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

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

Benefits for organ, tissue and bone marrow transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

Benefits as specified in this section will be provided for treatment and care as a result of or directly related to the following transplant procedures:

Solid Human Organ Transplants

- Liver.
- Heart.
- Lung.
- Heart-Lung.
- Kidney.

- Pancreas.
- Kidney/Pancreas.
- Small bowel.
- Other solid organ transplant procedures which we determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.

Tissue Transplant Procedures (Autologous and Allogeneic)

- Blood transfusions.
- Autologous parathyroid transplants.
- Corneal transplants.
- Bone and cartilage grafting.
- Skin grafting.
- Autologous islet cell transplants.
- Other tissue transplant procedures which we determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case-by-case basis.

Bone Marrow Transplants

- Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.
- Other bone marrow transplant procedures which we determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These bone marrow transplant procedures will be considered on a case-by-case basis.

33. Urgent Care Center Services

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

34. Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of medical and behavioral health conditions. Virtual care provides communication of medical information in real-time or asynchronous time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by visiting benefits.surest.com or calling the telephone number on your ID card.

Benefits are available for the following:

- Primary care, which is general and non-emergency care, delivered through live video, audio only technology, or through federally compliant secure messaging applications with, or supervised by, a Primary Care Physician.

- Mental Health Care Services and Substance-Related and Addictive Disorders Services, delivered through video, audio only technology, or through federally compliant secure messaging applications with, or supervised by, a properly qualified behavioral health provider.
- Specialty care, delivered through live video or audio only technology, or through federally compliant secure messaging applications with, or supervised by, a Specialist. Please refer to the *Schedule of Benefits* for specialties that are available virtually.
- Urgent on-demand health care delivered through live video, audio only technology, or through federally compliant secure messaging applications for treatment of acute but non-emergency medical needs.

Please Note: Not all medical and behavioral health conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician or behavioral health provider contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (CMS defined originating facilities).

35. Vision Exams

Routine vision exams received from a health care provider in the provider's office or outpatient facility. Routine vision exams include refraction to find vision impairment.

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

Additional Benefits Required By Louisiana Law

36. Attention Deficit Disorder Services

Benefits for the diagnosis and treatment of attention deficit/hyperactivity disorder.

37. Autism Spectrum Disorders Treatment Services

Benefits for the medical habilitative and rehabilitative treatment of an Autism Spectrum Disorder. Benefits for psychiatric treatment of Autism Spectrum Disorder are provided as described under *Mental Health Care and Substance-Related and Addictive Disorder Services*.

38. Bilateral Mastectomy Cancer Screening

Benefits for cancer screening are available, on no less than an annual basis, to qualified Covered Persons who were previously diagnosed with breast cancer, completed treatment for the breast cancer, underwent bilateral mastectomy and subsequently determined to be clear of cancer.

39. Cleft Lip and Cleft Palate Services

Benefits for the following:

- Oral and facial surgery, surgical management and follow-up care.
- Prosthetic treatment, such as obturators, speech appliances and feeding appliances.
- Orthodontic treatment and management.
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
- Speech-language evaluation and therapy.
- Audiological assessments and amplification devices.
- Otolaryngology treatment and management.

- Psychological assessment and counseling.
- Genetic assessment and counseling for the patient and parents.
- Treatment of secondary conditions attributable to the primary medical condition.

40. Dental Services - Hospitalization and General Anesthesia

Benefits include general anesthesia and associated facility charges when the mental or physical condition of a Covered Person requires dental treatment to be rendered in a Hospital setting. Benefits do not include treatment for temporomandibular joint syndrome (TMJ).

For a patient to satisfy the Benefit requirements described, a dentist shall consider the Indications for General Anesthesia, as published in the reference manual of the *American Academy of Pediatric Dentistry*, as utilization standards for determining whether performing dental procedures necessary to treat the particular condition or conditions of the patient under general anesthesia constitutes appropriate treatment. We may restrict coverage only to procedures performed by:

- A fully accredited specialist in pediatric dentistry or other dentists fully accredited in a recognized dental specialty for which Hospital privileges are granted.
- A dentist who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.
- A dentist who has not yet satisfied the certification requirements, but has been granted hospital privileges as of January 1, 1998.

41. Qualified Interpreter/Translator Services

Services of a qualified interpreter/translator, other than the Covered Person's family member, when such services are used by the Covered Person in connection with medical treatment or diagnostic consultations, provided the services are required because of a hearing impairment of the Covered Person or a failure of the Covered Person to understand or otherwise communicate in spoken language.

42. Telehealth Services

Benefits are available for applicable Covered Health Care Services transmitted via electronic imaging or telehealth from one site to another. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth does not include virtual care services provided by a Designated Virtual Network Provider for which Benefits are provided as described under *Virtual Care Services*.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

1. Health care services ordered by or rendered by providers or para-professionals unlicensed by the appropriate regulatory agency.
2. Acupressure.
3. Aromatherapy.
4. Hypnotism.
5. Massage therapy that is not physical therapy or prescribed by a licensed provider as a component of multi-modality rehabilitation treatment plan, except when provided by a chiropractor acting within the scope of his or her license.
6. Rolfing, except when provided by a chiropractor acting within the scope of his or her license.
7. Wilderness, adventure, camping, outdoor, or other similar programs.
8. Vocational therapy.
9. Homeopathic or naturopathic medicine, including dietary supplements.
10. Holistic medicine and services, including dietary supplements.
11. Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-

manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*. This exclusion does not apply to services for Autism Spectrum Disorders for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

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

This exclusion does not apply to dental anesthesia and facility charges received in a Hospital for which Benefits are provided as described under *Dental Services - Hospitalization and General Anesthesia* in *Section 1: Covered Health Care Services*.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
 - Removal, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident and Medical* in *Section 1: Covered Health Care Services*. This exclusion does not apply to cleft lip and cleft palate services for which Benefits are provided as described in *Section 1: Covered Health Care Services* under *Cleft Lip and Cleft Palate Services*.

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

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies and Prosthetic Services* in *Section 1: Covered Health Care Services*.
3. The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies and Prosthetic Services* in *Section 1: Covered Health Care Services*.
 5. Communication aids or devices; equipment to create, replace or augment communication abilities including speech processors, receivers, and communication boards; or computer or electronic assisted communication.
 6. Oral appliances for snoring.
 7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
 8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
 9. Powered and non-powered exoskeleton devices.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs that meet the requirements of a PPACA Zero Cost Share Preventive Care Medications under the *Outpatient Prescription Drug Rider*.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year. This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services*.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations will occur no more often than annually on the Policy anniversary date.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to

another covered Pharmaceutical Product. Such determinations will occur no more often than annually on the Policy anniversary date.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more often than annually on the Policy anniversary date.
12. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
13. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

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

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

This exclusion does not include a Prescription Drug Product that has been prescribed for the treatment of metastatic or unresectable tumors or other advanced cancers, if the drug is approved by the *U.S. Food and Drug Administration* for the treatment of cancers with specific mutations and the patient's cancer has been determined to contain the specific mutation, and there is no alternative treatment, or the patient has contraindication to the alternative treatment, that has proven to be more effective in published randomized clinical trials. Coverage for the treatment of metastatic or unresectable tumors or other advanced cancers will be for an initial trial of three months of therapy and will continue providing that the treating Physician certifies that the drug is Medically Necessary based on documented improvement of the patient.

Also not included are those drugs involving a minor on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved by *U.S. Food and Drug Administration* and all of the following apply: (1) The drug has been approved by the FDA; (2) The drug is prescribed by a licensed healthcare provider for the treatment of a life threatening, chronic, or seriously debilitating disease or condition in a minor and the drug has been approved by the FDA for the same condition or disease in an adult and the drug is medically necessary to treat the disease or condition; (3) The drug has been recognized for the treatment of the disease or condition in pediatric application by one of the following: (a) *The American Medical Association Drug Evaluations*, (b) *The American Hospital Formulary Service Drug Information*, (c) *The United States Pharmacopeia Dispensing Information*, Volume 1, "Drug Information for the Health Care Professional", (d) Recognized in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed journal; (4) The drug is on the our prescription drug list.

F. Foot Care

1. Routine foot care. Examples include:
 - Cutting or removal of corns and calluses.
 - Nail trimming, nail cutting, or nail debridement.
 - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.
5. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.
6. Shoe inserts.
7. Arch supports.

G. Gender Dysphoria

1. Cosmetic Procedures, including the following:
 - Abdominoplasty.
 - Blepharoplasty.
 - Body contouring, such as lipoplasty.
 - Brow lift.
 - Calf implants.
 - Cheek, chin, and nose implants.
 - Injection of fillers or neurotoxins.
 - Face lift, forehead lift, or neck tightening.
 - Facial bone remodeling for facial feminizations.
 - Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
 - Hair transplantation.
 - Lip augmentation.
 - Lip reduction.
 - Liposuction.
 - Mastopexy.
 - Pectoral implants for chest masculinization.
 - Rhinoplasty.
 - Skin resurfacing.

H. Medical Supplies and Equipment

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

- Ace bandages.
- Gauze and dressings.
- Bandages and tape.
- Antiseptics.
- Diapers and incontinence supplies.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies and Prosthetic Services* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
 - Disposable medical equipment or supplies related to and necessary for the administration of covered prescription drugs, such as syringes and needles provided under the *Outpatient Prescription Drug Rider*.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies and Prosthetic Services* in *Section 1: Covered Health Care Services*.
 3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
 4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
 5. Over-the-counter medical equipment or supplies such as saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a prescription even if a prescription has been ordered.

I. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. *Intense Early Intervention Using Behavioral Therapy (IEIBT)* and Lovaas. This exclusion does not apply when required for the treatment of Autism Spectrum Disorder.
3. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services, (including recovery residences).
8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
9. Residential care for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
10. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

J. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is a part of treatment.
 - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula and prescribed donor milk for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
 - Car seats.

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

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
 - Treatments for hair loss.

- Varicose vein treatment of the lower extremities.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
 4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
 5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. This exclusion does not include weight management programs as recommended under *PPACA* by the *United States Preventive Services Task Force (USPSTF)*.
 6. Scalp/cranial hair prostheses (wigs) except for Covered Persons with scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment. This exclusion does not include Manipulative Treatment, including a chiropractor acting within the scope of his or her license.
4. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
5. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
6. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
7. Upper and lower jawbone surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment. This exclusion does not apply to surgery for which Benefits are provided as described under *Temporomandibular Joint (TMJ) Services and Orthognathic Surgery* in *Section 1: Covered Health Care Services*.
8. Surgical and non-surgical treatment of obesity.
9. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
10. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
11. Helicobacter pylori (H. pylori) serologic testing.
12. Intracellular micronutrient testing.

13. Chelation therapy, except to treat heavy metal poisoning.
14. Cellular and Gene Therapy services not received from a Designated Provider.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services ordered or delivered by a Christian Science practitioner.
4. Service performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
 - Has not been involved in your medical care prior to ordering the service, or
 - Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

O. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
2. The following services related to a Gestational Carrier or Surrogate:
 - All costs related to reproductive techniques including:
 - ♦ Assisted reproductive technology.
 - ♦ Artificial insemination.
 - ♦ Intrauterine insemination.
 - ♦ Obtaining and transferring embryo(s).
 - ♦ Preimplantation Genetic Testing (PGT) and related services.
 - Health care services including:
 - ♦ Inpatient or outpatient prenatal care and/or preventive care.
 - ♦ Screenings and/or diagnostic testing.
 - ♦ Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
 - All fees including:
 - ♦ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
 - ♦ Surrogate insurance premiums.

- ♦ Travel or transportation fees.
- 3. Costs of donor eggs and donor sperm.
- 4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
- 5. The reversal of voluntary sterilization.
- 6. Elective fertility preservation.
- 7. In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.

P. Services Provided under another Plan

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

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. This exclusion does not apply if you have continued coverage during a leave to perform services in the uniformed services as described under *Continuation of Coverage During a Period of Service in the Uniformed Services* in *Section 4: When Coverage Ends*.
4. Health care services during active military duty. This exclusion does not apply if you have continued coverage during a leave to perform services in the uniformed services as described under *Continuation of Coverage During a Period of Service in the Uniformed Services* in *Section 4: When Coverage Ends*.

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants.

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services*.

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to eyeglasses and contacts required due to cataract surgery or aphakia for which Benefits are provided as described in *Section 1: Covered Health Care Services* under *Durable Medical Equipment, Orthotics, Prosthetic Devices, Supplies and Prosthetic Services*.
2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants), artificial retinal devices, or retinal implants.
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery (e.g. Lasik).
5. Bone anchored hearing aids except when either of the following applies:
 - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
 - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

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

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

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
 - Medically Necessary.
 - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption, or as the result of incarceration. This exclusion does not apply to immunizations for Enrolled Dependent children from birth to age six for which Benefits are provided as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
 - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
 3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones. This exclusion does not apply if you have continued coverage during a leave to perform services in the uniformed services as described under *Continuation of Coverage During a Period of Service in the Uniformed Services* in *Section 4: When Coverage Ends*.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Co-payments or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments are waived.
 7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Autopsy and other coroner services and transportation services for a corpse.
 10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider. This exclusion does not apply to interpreter services for which Benefits are provided as described under *Qualified Interpreter/Translator Services* in *Section 1: Covered Health Care Services*.
 11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

12. Charges for:
 - Missed appointments.
 - Completion of claims forms.
 - Record processing.
13. Over-the-counter self-administered home diagnostic tests, including HIV and Pregnancy tests.
14. Retail genetic tests direct to consumer.
15. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits are subject to your previous carrier's obligations under state law or contract.

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

What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under Medicare Part B.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *How Are Benefits Paid When You Are Medicare Eligible?* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

Eligibility for enrollment is administered by the Group consistent with the Policy which includes this *Certificate* and *Group Application*.

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

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

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

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

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group in accordance with the eligibility rules. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

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

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Coverage will not be cancelled due to nonpayment of Premium for a newborn Dependent child who at birth meets the eligibility provisions as set forth in state laws, rules or regulations implementing the *State Plan Medical Assistance* under *Title XIX of the Social Security Act*, until we have provided the secretary of the *Louisiana Department of Health* 90 days written notice of such cancellation thereof via United States mail, certified, return receipt requested. If Premium remains unpaid after the notice period, we will cancel the coverage for the newborn Dependent child effective as of the date of the birth of such child.

A Newly Born Child must be provided automatic coverage for one month from child's birth or until the child can be discharged home from the Hospital or neonatal special care unit to his home, whichever period is longer.

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

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

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Coverage for a Disabled Dependent Child

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

- The incapacity existed prior to the attainment of the limiting age.
- The Enrolled Dependent child is not capable of self-sustaining employment because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

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

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

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year after the two-year period following the child's attainment of the limiting age.

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

Continuation of Coverage

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

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

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

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

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

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

Qualifying Events for Continuation Coverage under State Law

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

- Termination of the Subscriber from employment with the Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Group will provide you with written notification of the right to continuation coverage within 14 days of when coverage ends under the Policy. You must elect continuation coverage within 10 days of receiving this notification. You should get an election form from the Group or the employer and, once election is made, forward all monthly Premiums to the Group for payment to us.

Terminating Events for Continuation Coverage under State Law

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

- 12 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

Continuation of Coverage During a Period of Service in the Uniformed Services

If your coverage would otherwise terminate due to a leave of employment to perform service in the uniformed services, you are entitled to continue coverage for yourself and your Enrolled Dependent.

Your Enrolled Dependent who is subsequently called to services in the uniformed services will continue to be considered a Dependent under the Policy without any lapses coverage, provided that all required contributions are made.

The Group will notify you of your right to continue coverage at the time you notify the Enrolling Group if you leave to perform service in the uniformed services. You should obtain an election form from the Group or your employer and, once election is made, forward all monthly Premiums to the Group for payment to us. Continuation must be elected prior to termination of coverage under the Policy.

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

- The date you return from active service in the uniformed services.
- The date coverage ends for failure to make timely payment of Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

If you or your Enrolled Dependent do not elect continuation coverage and you or your Enrolled Dependent are released from service in the uniformed services, you or your Enrolled Dependent may enroll under the Policy. If you did elect continuation coverage, the continuation coverage ends on the date you or your Enrolled Dependent's coverage under the Policy is effective.

Continuation of Coverage for Surviving Spouse or Domestic Partner and Children of Law Enforcement Officers

The Group of a law enforcement officer who suffers death as a result of any injury arising out of and in the course of the performance of his or her official duties as an officer, or arising out of any activity while on or off duty in her or her capacity as a law enforcement officer in the protection of life or property shall provide and pay for continuation coverage for the law enforcement officer's surviving spouse or Domestic

Partner for two years following the death of the law enforcement officer. The Group shall also pay for continuation coverage for the law enforcement officer's child, stepchild, or adopted child who is either:

- Under the age of eighteen.
- Under the age of twenty-three and enrolled in and regularly attending a secondary school or is a full-time student at an accredited college or university.
- Physically or mentally disabled.
- The Group shall provide and pay for the continuation coverage for two years following the death of the law enforcement officer or until the child no longer meets the qualifications listed above, whichever comes first.
- If coverage is offered by the Group to active Subscribers, the coverage provided to a surviving spouse or Domestic Partner or child, pursuant to this subsection, shall be equal in coverage to that offered to active Subscribers.
- The surviving spouse or Domestic Partner shall have the option to decline the coverage pursuant to this subsection.

The surviving parent or legal guardian of each child, stepchild, or adopted child of the deceased law enforcement officer shall have the option to decline the coverage in this subsection for the child.

Section 5: How to File a Claim

Louisiana Notice

YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

Louisiana Disclosure Notice

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THESE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, call the telephone number on your ID card. However, you are required to pay any required Co-payments to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below. Once an appropriate request for payment is received by us, as a result of an Emergency, we will make direct payment to the out-of-Network provider.

You should submit a request for payment of Benefits within 90 days after the date of service. Failure to submit the request within this timeframe will neither invalidate nor reduce your claim if it was not reasonably possible to submit the request within the 90-day timeframe, provided your request is submitted as soon as reasonably possible and in no event later than one year from the time proof is otherwise required. If you don't provide this information to us within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name, address, tax identification number, NPI number and license number, if available, of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.

- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).
- Proof of payment may be requested to substantiate your claim but is not required upon initial submission.

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

When filing a claim for Outpatient Prescription Drug Benefits, your claim should be submitted by mail to:

Optum Rx
PO Box 650629
Dallas, TX 75265-0629

Payment of Benefits

If you provide written authorization to allow this, all or a portion of any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

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

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

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

For any non-electronic claim submitted by a Network provider within 45 days of the date of service or date of discharge from a health care facility or institution, we will pay, deny or pend Benefits not more than 45 days from the date upon which a non-electronic Clean Claim is received by us, unless just and reasonable grounds exist to put a reasonable and prudent businessman on his guard.

For any non-electronic claim submitted by a Network provider more than 45 days of the date of service, or date of discharge from a health care facility or institution, or resubmitted because the original claim form was not an Accepted Claim form or was not a Clean Claim, we will pay, deny or pend Benefits not more than 60 days from the date upon which a non-electronic Clean Claim is received by us, unless just and reasonable grounds exist to put a reasonable and prudent businessman on his guard.

Except for Covered Health Care Services that are subject to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*, for any other non-electronic claim submitted by a Covered Person or by an out-of-Network provider, we will pay, deny, or pend Benefits not more than 45 days from the date upon which a non-electronic Clean Claim is received by us, unless just and reasonable grounds exist to put a reasonable and prudent businessman on his guard.

Within five working days of receipt of any electronic claim, we will review the claim and if we determine that the claim is not an Accepted Claim, we will issue an electronic report to the health care provider indicating all defects or reasons known at that time that the claim is not an Accepted Claim. If we fail to provide such a report, the provider will be deemed to have timely submitted a claim for payment.

Any electronic claim will be paid, denied or pended not more than twenty-five days from the date upon which an electronic Clean Claim is electronically received by us unless just and reasonable grounds exist to put a reasonable and prudent businessman on his guard.

We will provide written notice to health care provided that a claim is pended. For the purpose of this section, "Just reasonable grounds" will include, but is not limited to, determination of whether or not the Covered Person was eligible for health insurance coverage on the date health care services were rendered.

Any health care provider that is not paid within the time frames specified in this section will receive a late payment adjustment equal to twelve percent per annum of the amount due.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

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

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of

the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

An "Adverse Benefit Determination" means any of the following:

- A determination by us or our designee utilization review organization that, based upon the information provided, a request for a Benefit under the Policy upon application of any utilization review technique does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be an Experimental or Investigational Service and the requested Benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by us or our designee utilization review organization of a Covered Person's eligibility to participate in the health benefit plan.
- Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a Benefit under the Policy.
- The denial, reduction or termination of concurrent care.
- A rescission of coverage determination.

In addition to calling us at the telephone number shown on your ID card, you may also seek assistance with the Appeals Process by contacting the *Office of Consumer Advocacy* within the *Louisiana Department of Insurance* via the following:

Louisiana Department of Insurance

Office of Consumer Services

P.O. Box 94214

Baton Rouge, LA 70804-9214

Phone: (225) 219-0619 or (800) 259-5300

www.lidi.la.gov

Appeals Determinations

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

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

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as defined above, the appeal will take place and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision. You or your authorized representative may simultaneously file both an expedited appeal of a grievance involving an Adverse Benefit Determination and an expedited external review if the time frame for completion of the expedited review of the grievance would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function. The Independent Review Organization (IRO) assigned to conduct the expedited external review will determine whether the Covered Person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Upon receiving an external review request, we will notify the Commissioner that the request is eligible for external review by submitting a request for assignment of an independent review organization through the Department of

Insurance's website. Upon receipt of our notification, the Commissioner will randomly assign an Independent Review Organization from a list of approved independent review organizations.

There are four types of external reviews available:

- A standard external review.
- An expedited external review.
- A standard external review of experimental or investigational treatment adverse determinations.
- An expedited external review of experimental or investigational treatment adverse determinations.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the Louisiana Department of Insurance for random assignment to an IRO.
- A decision by the IRO.

Within five business days after receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you regarding your request's eligibility for external review. We will notify you or your authorized representative and the Commissioner of insurance if the request is eligible for external review. The Commissioner will then randomly assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner to conduct the external review. We will inform you or your authorized representative and the insurance Commissioner if the request is not eligible for external review and the reasons for the ineligibility. If the request is incomplete, you will be informed about the reasons for the incompleteness and the information or materials needed to make the request complete. Our decision to deny the external review request may be appealed to the Commissioner.

You may submit in writing to the IRO within five business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after five business days.

We will provide to the assigned IRO the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by us. The IRO will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request

additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

If we receive a *Final External Review Decision* reversing our determination, we will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with our determination, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
 - The life or health of the individual.
 - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
 - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
 - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you and, if applicable, your authorized representative regarding the request's eligibility for expedited external review. You or your authorized representative may appeal to the commissioner if we determine that your expedited request is ineligible for review. Upon a determination that a request is eligible for expedited external review, the commissioner will assign an *IRO* in the same manner utilized to assign standard external reviews to *IROs*. We will provide all necessary documents and information considered in making the Adverse Benefit Determination or final Adverse Benefit Determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the *IRO's* final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call us at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

External Review of Experimental or Investigational Treatment Adverse Benefit Determinations

Within four months after the date of receipt of a notice of an Adverse Benefit Determination or final Adverse Benefit Determination pursuant to a notice of right to external review that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is an Experimental or Investigational Service, you or your authorized representative may file a request for a standard and an expedited external review with us, regardless of the claim amount.

You or your authorized representative may make an oral request to us for an expedited external review of such an Adverse Benefit Determination or final Adverse Benefit Determination if your treating physician certifies, in writing, that any delay in appealing the Adverse Benefit Determination may pose an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health.

Upon notice of the request for an expedited external review, we will immediately determine whether the request meets the preliminary reviewability requirements as identified under this Section. We will immediately notify you and, if applicable, your authorized representative of our eligibility determination. This notice of initial determination will include a statement informing you and, if applicable, your authorized representative that the expedited external review request is ineligible for review may be appealed to the Commissioner.

If you or your authorized representative makes a written request to the Commissioner after receipt of the denial of an expedited external review, the Commissioner may determine that a request is eligible for an expedited external review and require that it be referred for an expedited external review. The Commissioner will immediately notify us and you or your authorized representative of his or her determination concerning the eligibility of the request. Following receipt of the Commissioner's determination that a request is eligible for an expedited external review, we will comply.

Immediately upon our determination that a request is eligible for an expedited external review or upon the determination by the Commissioner that a request is eligible for an expedited external review, we will submit a request for assignment of an *IRO* through the *Louisiana Department of Insurance's* website. The Commissioner will immediately randomly assign an *IRO* to review the expedited request and notify us and you or your authorized representative of the name and contact information of the assigned *IRO*.

At the time we receive the notice of the assigned *IRO*, we or our designee utilization review organization will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final Adverse Benefit Determination to the assigned *IRO* electronically, by telephone or facsimile, or any other available expeditious method.

Within five (5) business days following the date of receipt of the standard external review request, we will conduct and complete a preliminary review of the request to determine whether each of the following conditions has been met:

You are or were in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was in the health benefit plan at the time the health care service or treatment was provided.

The recommended or requested health care service or treatment that is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination is not explicitly listed under *Section 2: Exclusions and Limitations* in this **Certificate**.

Your treating physician has certified that one of the following situations exists:

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

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

There is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment.

Your treating physician either:

Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to you, in the physician's opinion, than any available standard health care services or treatments, or

Is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat your condition and has certified, in writing, that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by you that is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination is likely to be more beneficial to you than any available standard health care services or treatments.

You have exhausted our internal claims and appeals process.

You have provided all the information and forms required by the Commissioner that are necessary to process a standard external review, including any required authorization form.

Within five business days after the completion of the preliminary review, we will notify you and, if applicable, your authorized representative in writing whether each of the following conditions have been met:

The request is complete.

The request is eligible for a standard external review.

If the request is not complete, we will inform you and, if applicable, your authorized representative in writing and specify in the notice what information or materials are needed to make the request complete. If the request is not eligible for a standard external review, we will inform you and your authorized representative, if applicable, in writing and include in the notice the reasons for its ineligibility.

The notice of initial determination will include a statement informing you and, if applicable, your authorized representative that our initial determination that the standard external review request is ineligible for review may be appealed to the Commissioner.

If you or your authorized representative makes a written request to the Commissioner after receipt of the denial of a standard external review, the Commissioner may determine that a request is eligible for a standard external review under the preliminary reviewability requirements, notwithstanding our initial determination that the request is ineligible, and require that it be referred for a standard external review. The Commissioner will notify us and you or your authorized representative of his or her determination concerning the eligibility of the request within five business days. We will comply following receipt of the Commissioner's determination that a request is eligible for a standard external review.

We will notify the Commissioner that a request is eligible for a standard external review by submitting a request for assignment of an *IRO* through the *Louisiana Department of Insurance's* website. Upon notification, the Commissioner will do both of the following:

Assign an *IRO* to conduct the standard external review from the list of approved *IROs* and notify us of the name of the assigned *IRO*.

Within one business day, notify you in writing and, if applicable, your authorized representative of the request's eligibility and acceptance for a standard external review and the identity of and contact information for the assigned *IRO*.

You or your authorized representative may submit in writing to the assigned *IRO*, within five business days following the date of receipt of the notice, additional information that the *IRO* will consider when conducting the standard external review. The *IRO* will be authorized, but not required to accept and consider additional information submitted after five business days. Within one business day after the receipt of the notice of assignment to conduct the standard external review, the assigned *IRO* will follow the clinical peer process identified below.

For both a standard and an expedited external review, the assigned *IRO* will do both of the following:

Select one or more clinical peers to conduct the standard or expedited external review,

Based on the opinion of the clinical peers selected to conduct the standard or expedited external review, make a decision to uphold or reverse the Adverse Benefit Determination or final.

Within five business days after the date of receipt of the notice provided, we or our designee utilization review organization will provide the documents and any information considered in making the Adverse Benefit Determination or the final Adverse Benefit Determination to the assigned *IRO*. Failure by us or our designee utilization review organization to provide the documents and information within this time frame will not delay the standard external review or the expedited external review. An exception to this will be if we or our designee utilization review organization has failed to provide the documents and information within the time frame, the assigned *IRO* may terminate the standard external review or the expedited external review and make a decision to reverse the Adverse Benefit Determination or final Adverse Benefit Determination. Immediately upon making this decision, the *IRO* will notify you, your authorized representative, if applicable, us, and the Commissioner.

Within one business day after receipt of any information submitted by you or your authorized representative, the assigned *IRO* will forward the information to us.

Upon receipt of the information required to be forwarded, we may reconsider our Adverse Benefit Determination or final Adverse Benefit Determination that is the subject of the standard or the expedited external review. Reconsideration by us of our Adverse Benefit Determination or final Adverse Benefit Determination will not delay or terminate the standard or the expedited external review. The standard or the expedited external review may terminate only if we decide, upon completion of our reconsideration, to reverse our Adverse Benefit Determination or final Adverse Benefit Determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination. For a standard or an expedited review, immediately upon making the decision to reverse our Adverse Benefit Determination or final Adverse Benefit Determination, we will notify you, your authorized representative, if applicable, the assigned *IRO*, and the Commissioner in writing of our decision. The assigned *IRO* will terminate the standard or the expedited external review upon receipt of the notice from us.

Within 20 days after being selected to conduct the standard external review, each clinical peer will provide an opinion to the assigned *IRO* regarding whether the recommended or requested health care service or treatment should be covered.

For an expedited external review, each clinical peer shall provide an opinion to the assigned *IRO* as expeditiously as your medical condition or circumstances requires, but in no event more than five days after being selected. If the opinion was not in writing, within 48-hours following the date that the opinion was provided, the clinical peer shall provide written confirmation of the opinion to the assigned *IRO* and include the information required above.

Within 20 days after the date it receives the opinion of each clinical peer, the assigned *IRO* in a standard external review, will make a decision and provide written notice of the decision to you; if applicable, your authorized representative, us, and the Commissioner.

For an expedited external review, within 48-hours after the date it receives the opinion of each clinical peer, the assigned *IRO*, will make a decision and provide notice of the decision orally or in writing to the persons specified above. If this notice was not in writing, within 48-hours after the date of providing that notice, the assigned *IRO* will provide written confirmation of the decision to the persons specified above and include the information provided below for a standard or an expedited appeal.

For a standard or an expedited review, if a majority of the clinical peers recommend that the recommended or requested health care service or treatment should be covered, the *IRO* will make a decision to reverse our Adverse Benefit Determination or final Adverse Benefit Determination. For a standard or an expedited external review, if a majority of the clinical peers recommend that the recommended or requested health care service or treatment should not be covered, the *IRO* will make a decision to uphold our Adverse Benefit Determination or final Adverse Benefit Determination. For a standard or an expedited external review, if the clinical peers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the *IRO* will obtain the

opinion of an additional clinical peer in order for the *IRO* to make a decision based on the opinions of a majority of the clinical peers made. The additional clinical peer selected will use the same information to reach an opinion as the clinical peers who have already submitted their opinions. The selection of the additional clinical peer will not extend the time within which the assigned *IRO* is required to make a decision based on the opinions of the selected clinical peers.

For a standard or an expedited external review, upon receipt of a notice of a decision reversing the Adverse Benefit Determination or final Adverse Benefit Determination, we will immediately approve coverage and payment of the recommended or requested health care service or treatment that was the subject of the Adverse Benefit Determination or final Adverse Benefit Determination.

You may contact us at the toll-free Member number on your ID card for more information regarding external review rights of Experimental or Investigational Treatment Adverse Benefit Determinations, or if making a verbal request for an expedited external review.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

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

- A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (see *Subrogation and Reimbursement* under *Section 8: General Legal Provisions* for coordination of benefits applicability of automobile medical payment coverage; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first

before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

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

What Are the Rules for Determining the Order of Benefit Payments?

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

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

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

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

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

- (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
- d)
 - (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 - (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
- 3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
- 4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
- 5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
- 6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the Primary Plan. As each claim is submitted, this Plan will:
 - 1. determine its obligation to pay or provide benefits under its contract;
 - 2. determine whether there are any unpaid allowable expenses during that claims determination period.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Part B.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Part B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Part B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Part B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under Medicare Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating the Coverage Plan's Benefit in these situations, we use the provider's billed charges as the Allowable Expense.

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

Consumer Explanatory Booklet Coordination of Benefits

Below is a summary of only a few of the provisions of your health plan to help you understand Coordination of Benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures and does not change or replace the language contained in this coverage Policy, which determines your Benefits.

When This Plan is Primary

Other Situations: We will be Primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the Primary Plan, we will pay the Benefits in accordance with the terms of your Policy, just as if you had no other health care coverage under any other Plan.

How We Pay Claims When We Are Secondary

We will be Secondary whenever the rules do not require us to be Primary.

How We Pay Claims When We Are Secondary

When we are the Secondary Plan, we do not pay until after the Primary Plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "Allowable Expense" is a health care service or expense covered by one of the plans, including Co-payments.

- If there is a difference between the amount the Plans allow, we will base our payment on the higher amount. However, if the Primary Plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the Primary Plan paid from the amount we would have paid if we had been Primary. We will use any savings to pay the balance of any unpaid Allowable Expenses covered by either Plan.
- We will not pay an amount the Primary Plan did not cover because you did not follow its rules and procedures. For example, if your Plan has reduced its benefit because you did not obtain pre-certification, as required by that Plan, we will not pay the amount of the reduction, because it is not an Allowable Expense.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

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

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

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

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider.

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.

- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments and any amount that exceeds the Allowed Amount, when applicable.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment as described in your *Schedule of Benefits*.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs, administrative programs, and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. You can visit benefits.surest.com or call the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment.

Who Interprets Benefits and Other Provisions under the Policy?

Subject to *Section 6: Questions, Complaints and Appeals*, we have the discretionary authority to do all of the following:

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

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

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

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.

- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

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

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under Medicare Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under Medicare Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

We have the right to subrogation and reimbursement. References to “you” or “your” in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Policy to treat your injuries. Under subrogation, the Policy has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Policy as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.
- Automobile insurer who is or may be obligated to provide medical payment coverage if written agreement exists between the parties and is in accordance with the *Louisiana Department of Insurance* coordination of benefits regulations. Nine months after the accident date from which medical claims exist, we may seek reimbursement from the automobile medical payments insurer for the outstanding balance remaining under the automobile medical coverage policy.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- To the extent allowed by law, our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries.
- Benefits paid by us may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- Subject to *Section 6: Questions, Complaints and Appeals*, we have the discretionary authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- That if you fully recover your damages from third parties, then you will reimburse us the portion of the damages recovered for the expenses incurred by the Covered Person that were provided or paid by us.
- That in the event you fail to take appropriate action to make recovery from a third party we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid

relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- Subject to *Section 6: Questions, Complaints and Appeals*, we and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

The foregoing subrogation and reimbursement provisions are subject to the following where applicable:

- We agree to pay our portion of your attorney's fee or other costs associated with a claim or lawsuit to the extent that we recover any portion of the Benefits paid under the Policy including those attorney's fees incurred in obtaining a recovery from the third party as a result of our invoking a subrogation or reimbursement provision.
- That our right to subrogation granted under this provision may not be enforced until you have been fully compensated or made whole.

When Do We Receive Refunds of Overpayments?

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

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

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

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

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

Physical Examinations

We have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Extension of Time Limitations

If any limitation of this Policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this Policy is less than that permitted by law of the state, district or territory in which the insured resides at the time this Policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Accepted Claim - a non-electronic claim on a HCFA 1500 form or Uniform Billing form 92(UB04), properly completed according to Medicare guidelines, or an electronic claim in a 837 format or its successor adopted by the *United States Department of Health and Human Services* or its successor, in compliance with the provisions of the *Health Insurance Portability and Accountability Act*.

Air Ambulance - medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in 42 CFR 414.605.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us or determined as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings generally in accordance with one or more of the following methodologies:

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

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

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

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Autism Spectrum Disorder - any of the pervasive developmental disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Clean Claim - an Accepted Claim that has no defect or impropriety including any lack of required substantiating documentation or other particular circumstances requiring special treatment that prevents timely payment from being made on the claim.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Convenience Care Clinic - a category of walk-in clinic located in retail stores, supermarkets and pharmacies that treat uncomplicated minor Sickness and provide preventive care services.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for Covered Health Care Services.

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

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, eligibility for enrollment and qualification as a Dependent is administered by the Group consistent with the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application*. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed in foster care.

- A child placed for adoption. "Placed for adoption" means the assumption and retention by the Subscriber or the Subscriber's spouse or Domestic Partner of a legal obligation for total or partial support of the child in anticipation of adoption of the child.
- A child placed in your home following the execution of an act of voluntary surrender in favor of you or your legal representative.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A grandchild who is residing with and under the legal custody of either the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month during which the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month during which the child reaches age 26.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Provider - a provider and/or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by visiting benefits.surest.com or calling the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only, and/or through federally compliant secure messaging applications.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.

- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - They have a single dedicated relationship of at least 6 months.
 - They have joint ownership of a residence.
 - They have at least two of the following:
 - ♦ A joint ownership of an automobile.
 - ♦ A joint checking, bank or investment account.
 - ♦ A joint credit account.
 - ♦ A lease for a residence identifying both partners as tenants.
 - ♦ A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility rules in accordance with the Policy which includes this *Certificate* and the Group *Application*. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).

- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
 - e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Employee - any individual employed by an employer. Employee is also referred to as a Subscriber in the Certificate.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

E-Visit - services provided by a Physician without face to face interaction through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal message.

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
 - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
 - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
 - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

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

- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
 - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*; and
 - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Drugs prescribed for the treatment of cancer on the grounds that the drug is not approved by the *United States Food and Drug Administration* for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature. Such drug coverage will also include all Medically Necessary services which are associated with the administration of the drug.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

A Hospital includes an institution that is owned and operated by the State of Louisiana.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Care Services.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Large Employer - in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

Level 1 Procedure - category of minor procedures typically performed in an outpatient office setting.

Level 2 Procedure - category of minor surgeries and procedures or services typically performed in an outpatient Hospital setting.

Level 3 Procedure - category of major surgeries and procedures typically performed in an outpatient or inpatient Hospital setting.

Level 4 Procedure - category of major surgeries typically performed in an inpatient Hospital setting.

Level 5 Procedure - category of more complex major surgeries typically performed in an inpatient Hospital setting.

Life-Threatening - a severe, serious or acute condition for which death is probable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that are all of the following as determined by us or our designee:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is

listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Newly Born Child - an infant from the time of birth until age one month or until such time as the infant is well enough to be discharged from a Hospital or neonatal special care unit to the infant's home, whichever period is longer.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment/High Intensity Outpatient - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)* -approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law. You will, however, be allowed direct and routine care to an obstetrician/gynecologist as required by State law. We may require the treating obstetrician/gynecologist to coordinate such care with your Primary Physician.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- *Group Application.*
- *Riders.*
- *Amendments.*

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT) - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M: For monogenic disorder (formerly single-gene PGD).
- PGT-SR: For structural rearrangements (formerly chromosomal PGD).

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Prosthetic Services - the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It shall also include and Medically Necessary clinical care.

Recognized Amount - the amount which the Co-payment is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.

- Non-Emergency Covered Health Care Services received at certain Network facilities by 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*. 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 described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

- 1) An *All Payer Model Agreement* if adopted,
- 2) State law, or
- 3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health care professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Secretary - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Severe Mental Illness - any of the following Mental Illnesses; schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; posttraumatic stress disorder; psychosis NOS (not otherwise specified) when diagnosed in a child under 17 years of age; Rett's Disorder; Tourette's Disorder.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Telehealth - live, interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth does not include virtual care services provided by a Designated Virtual Network Provider.

Temporarily Medically Disabled Mother - a woman who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

Please note:

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

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

Section 10: Consolidated Appropriations Act Summary

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act")* (P.L. 116-260).

No Surprises Act

Balance Billing

Under the Act, the *No Surprises Act* prohibits balance billing by out-of-Network providers in the following instances:

- When Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- When non-Ancillary Services are 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 in the Act.
- When Emergency Health Care Services are provided by an out-of-Network provider.
- When Air Ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment (cost share). Your cost share will be provided at the same level as if provided by a Network provider and is determined based on the Recognized Amount.

For the purpose of this Summary, "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 described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

Determination of Our Payment to the Out-of-Network Provider:

When Covered Health Care Services are received from out-of-Network providers for the instances as described above, Allowed Amounts, which are used to determine our payment to out-of-Network providers, are 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).

Continuity of Care

The Act provides that 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.

Provider Directories

The Act provides that 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 that would be no greater than if the service had been provided from a Network provider.

Surest Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

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*.

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 required prior authorization or pre-admission notification 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.

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 Benefits. | Network and Out-of-Network No Annual Deductible applies |
| Out-of-Pocket Limit | |
| <p>The maximum you pay per year for Co-payments. 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 <i>Schedule of Benefits</i>, including Covered Health Care Services provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>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:</p> <ul style="list-style-type: none"> 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. <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.</p> <p>Any amount that you pay for Covered Health Care Services that is applied to the Network Out-of-Pocket Limit will also be applied to the out-of-Network Out-of-Pocket Limit. Any amount you pay for Covered Health Care Services that is applied to the out-of-Network Out-of-Pocket Limit will not be applied to the Network Out-of-Pocket Limit.</p> | <p>Network \$9,000 per Covered Person. \$9,000 per Covered Person, not to exceed \$18,000 for all Covered Persons in a family.</p> <p>Out-of-Network \$18,000 per Covered Person. \$18,000 per Covered Person, not to exceed \$36,000 for all Covered Persons in a family.</p> |
| Co-payment | |
| <p>Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive Covered Health Care Services. Co-payments are shown as the amount is listed on the following pages next to the description for each Covered Health Care Service.</p> <p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> | |

| Payment Term And Description | Amounts |
|---|---------|
| <ul style="list-style-type: none"> • The applicable Co-payment. • The Allowed Amount or the Recognized Amount, when applicable. <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>In the Benefits table below, some Co-payments are listed as a range. Providers are assigned Co-payments within the range based on treatment outcomes and cost information that identifies Network providers that provide cost-efficient care.</p> <p>For Benefits listed with a Co-payment range or with a Co-payment maximum, you should visit benefits.surest.com, check the Surest app, or call the telephone number on your ID card for current provider specific Co-payment information.</p> | |

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 *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.

**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| 1. Acupuncture Services | | | |
| Limited to 60 treatments per year. Limits above do not apply for the treatment of Mental Illness or substance-related and addictive disorders. | Network \$70 per visit | Yes | |
| | Out-of-Network \$210 per visit | Yes | |
| 2. Ambulance Services | | | |
| <p style="text-align: center;">Prior Authorization Requirement</p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation.</p> <p>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.</p> | | | |
| Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> . | Network <i>Ground Ambulance</i> \$500 per transport | Yes | |
| | <i>Air Ambulance</i> \$500 per transport | Yes | |
| | Out-of-Network | | |

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|---|---|--|
| | <i>Ground Ambulance</i> \$500 per transport <i>Air Ambulance</i> Same as Network | Yes Same as Network | |
| 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 <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> . | Network <i>Ground Ambulance</i> \$500 per transport <i>Air Ambulance</i> \$500 per transport | Yes Yes | |
| | Out-of-Network <i>Ground Ambulance</i> \$500 per transport <i>Air Ambulance</i> Same as Network | Yes Same as Network | |
| 3. Cellular and Gene Therapy | | | |
| 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 <i>Schedule of Benefits</i> . | | |
| | Out-of-Network | | |

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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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | Out-of-Network Benefits are not available. | | |

4. 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.

| | |
|---|--|
| Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> . | <p>Network</p> <p>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 <i>Schedule of Benefits</i>.</p> |
| | <p>Out-of-Network</p> <p>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 <i>Schedule of Benefits</i>.</p> |

5. Dental Services - Accident and Medical

| | | | |
|--|----------------------------|-----|--|
| | Network | | |
| | <i>Oral Surgery</i> | | |
| | \$700 per visit | Yes | |
| | All Other Services | | |
| | <i>Inpatient</i> | | |
| | \$4,500 per Inpatient Stay | Yes | |

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | <i>Outpatient Hospital</i> *\$300 to \$1,300 per visit | Yes | |
| | <i>Outpatient Office Visit</i> *\$45 to \$155 per visit | Yes | |
| | <i>Out-of-Network</i> | | |
| | <i>Oral Surgery</i> \$2,000 per visit | Yes | |
| | <i>All Other Services</i> | | |
| | <i>Inpatient</i> \$13,000 per Inpatient Stay | Yes | |
| | <i>Outpatient Hospital</i> \$3,900 per visit | Yes | |
| | <i>Outpatient Office Visit</i> \$465 per visit | Yes | |

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. 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

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| Limited to one pair of therapeutic, custom-molded shoes, when prescribed by a Physician for the treatment of diabetes, per year. | training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . | | |
| | 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 <i>Schedule of Benefits</i> . | | |
| Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under <i>Durable Medical Equipment (DME)</i> , <i>Orthotics</i> , <i>Prosthetic Devices</i> , <i>Supplies</i> , and <i>Prosthetic Services</i> . | 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 <i>Durable Medical Equipment (DME)</i> , <i>Orthotics</i> , <i>Prosthetic Devices</i> , <i>Supplies</i> , and <i>Prosthetic Services</i> and in <i>Outpatient Prescription Drug Schedule of Benefits</i> . | | |
| | 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 <i>Durable Medical Equipment (DME)</i> , <i>Orthotics</i> , <i>Prosthetic Devices</i> , <i>Supplies</i> , and <i>Prosthetic Services</i> and in the <i>Outpatient Prescription Drug Schedule of Benefits</i> . | | |
| 7. Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies and Prosthetic Services. | | | |

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME, prosthetic

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|---------------------------------|---|--|
| devices, or orthotic. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. | | | |
| <p>For Durable Medical Equipment requiring prior authorization, reasonable quantity limits are determined by our utilization review organization using utilization review criteria. For supplies not requiring prior authorization, reasonable quantity limits are determined via a medical necessity review, also completed by our utilization review organization.</p> <p>To determine the tiers to which DME, orthotics, prosthetic devices, and supplies are assigned, visit benefits.surest.com or call the telephone number on your ID card.</p> <p>Hearing aids are limited to a single purchase per ear with hearing loss every 36 months.</p> <p>Scalp/cranial hair prosthesis (wigs) are limited to one per year.</p> <p>Cataract surgery or aphakia is limited to one eyeglasses frame and one pair of lenses, or one pair of contact lenses, or one year supply of disposable contact lenses.</p> <p>Note: Returning home with Durable Medical Equipment, such as crutches, after an appointment with a health care provider or from an outpatient</p> | Network | | |
| | <i>Tier 1</i> | | |
| | None per item | Yes | |
| | <i>Tier 2</i> | | |
| | \$20 per item | Yes | |
| | <i>Tier 3</i> | | |
| | \$40 per item | Yes | |
| | <i>Tier 4</i> | | |
| | \$60 per item | Yes | |
| | <i>Tier 5</i> | | |
| | \$80 per item | Yes | |
| | <i>Tier 6</i> | | |
| | \$100 per item | Yes | |
| | <i>Tier 7</i> | | |
| | \$150 per item | Yes | |
| | <i>Tier 8</i> | | |
| | \$200 per item | Yes | |
| | <i>Tier 9</i> | | |
| | \$250 per item | Yes | |
| | <i>Tier 10</i> | | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|----------------------------------|---|--|
| procedure or Inpatient Stay, may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. | \$350 per item <i>Tier 11</i> | Yes | |
| | \$500 per item <i>Tier 12</i> | Yes | |
| | \$1,000 per item | Yes | |
| | <i>Out-of-Network</i> | | |
| | <i>Tier 1</i> | | |
| | \$20 per item | Yes | |
| | <i>Tier 2</i> | | |
| | \$40 per item | Yes | |
| | <i>Tier 3</i> | | |
| | \$80 per item | Yes | |
| | <i>Tier 4</i> | | |
| | \$120 per item | Yes | |
| | <i>Tier 5</i> | | |
| | \$160 per item | Yes | |
| | <i>Tier 6</i> | | |
| | \$200 per item | Yes | |
| | <i>Tier 7</i> | | |
| | \$300 per item | Yes | |
| | <i>Tier 8</i> | | |
| | \$400 per item | Yes | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|---|---|--|
| | <i>Tier 9</i> \$500 per item | Yes | |
| | <i>Tier 10</i> \$700 per item | Yes | |
| | <i>Tier 11</i> \$1,000 per item | Yes | |
| | <i>Tier 12</i> \$2,000 per item | Yes | |
| 8. Emergency Health Care Services - Outpatient | | | |
| <p>Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the 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 Covered Health Care Service.</p> <p>If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as</p> | <p>Network \$1,000 per visit</p> | Yes | |

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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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|---|---|--|
| <p>described under <i>Hospital - Inpatient Stay</i> will apply. You will not have to pay the Emergency Health Care Services Co-payment.</p> <p>Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p> <p>Note: Returning home with Durable Medical Equipment, such as crutches, after an Emergency room visit may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i>.</p> | | | |
| | Out-of-Network Same as Network | Same as Network | |
| 9. Enteral Nutrition | | | |
| In addition to the Co-payment stated in this section, you will also be responsible for the Co-payment stated under the <i>Home Health Care</i> Benefit if you also receive services from a Home Health Agency. | <p>Network Same as <i>Durable Medical Equipment (DME), Orthotics, Prosthetics, Devices, and Supplies</i>.</p> <p>To determine the tiers to</p> | Yes | |

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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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| | which specialized enteral formulas are assigned, visit benefits.surest.com or call the telephone number on your ID card. | | |
| | <p>Out-of-Network Same as <i>Durable Medical Equipment (DME), Orthotics, Prosthetics, Devices, and Supplies</i>.</p> <p>To determine the tiers to which specialized enteral formulas are assigned, visit benefits.surest.com or call the telephone number on your ID card.</p> | Yes | |
| 10. Fertility Preservation for Iatrogenic Infertility | | | |
| Limited to \$10,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under <i>Preimplantation Genetic Testing (PGT) and Related Services</i> . Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage | <p>Network \$100 per visit</p> | Yes | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---|---|--|
| under the Policy. | | | |
| | Out-of-Network Out-of-Network Benefits are not available. | Out-of-Network Benefits are not available. | |

11. Gender Dysphoria

Prior Authorization Requirement for Surgical Treatment

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization 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 an Inpatient Stay.

It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Care Service is provided, any applicable 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 <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Rider</i> . |
| | Out-of-Network |

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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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | 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 <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Rider</i> . | | |

12. 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, 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 admissions or as soon as is reasonably possible for non-scheduled admissions.

| | | | |
|---|---|-----|--|
| Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under <i>Skilled Nursing Facility/Inpatient Rehabilitation Services</i> . | 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 <i>Schedule of Benefits</i> . | | |
| Outpatient therapies: <ul style="list-style-type: none"> Manipulative Treatment. Physical therapy. Occupational therapy. Speech therapy. Cognitive therapy. | Outpatient Manipulative Treatment \$40 per visit Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders | Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|---|---|--|
| For the above outpatient therapies: | | | |
| <ul style="list-style-type: none"> Limits will be the same as, and combined with, those stated under <i>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</i>. | \$35 per visit | Yes | |
| | <i>Occupational Therapy for All Other Conditions</i> | | |
| | *\$35 to \$140 per visit | Yes | |
| Note: Returning home with Durable Medical Equipment, such as a walker, following habilitative services may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i> . | <i>Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> | | |
| | \$35 per visit | Yes | |
| | <i>Physical Therapy for All Other Conditions</i> | | |
| | *\$35 to \$110 per visit | Yes | |
| | <i>Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> | | |
| | \$35 per visit | Yes | |
| | <i>Speech Therapy for All Other Conditions</i> | | |
| | *\$35 to \$140 per visit | Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | <i>Post-cochlear Implant Aural Therapy</i> *\$60 to \$150 per visit <i>Cognitive Therapy</i> **\$35 to \$140 per visit | Yes Yes | |
| | <i>Out-of-Network Inpatient</i> 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 <i>Schedule of Benefits</i> . | | |
| | <i>Outpatient Manipulative Treatment</i> \$120 per visit <i>Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> \$105 per visit <i>Occupational Therapy for All Other Conditions</i> \$420 per visit <i>Physical Therapy for the Treatment of Mental Illness and Substance-</i> | Yes Yes Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| | <i>Related and Addictive Disorders</i> \$105 per visit | Yes | |
| | <i>Physical Therapy for All Other Conditions</i> \$330 per visit | Yes | |
| | <i>Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> \$105 per visit | Yes | |
| | <i>Speech Therapy for All Other Conditions</i> \$420 per visit | Yes | |
| | <i>Post-cochlear Implant Aural Therapy</i> \$450 per visit | Yes | |
| | <i>Cognitive Therapy</i> \$420 per visit | Yes | |
| 13. Home Health Care | | | |
| <p align="center">Prior Authorization Requirement</p> <p>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, you will be responsible for paying all charges and no Benefits will be paid.</p> | | | |
| <i>Rehabilitative/Habilitative Services</i> | Network | | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| <p><i>provided in the home by other than a Home Health Agency</i></p> <p>Limit will be the same as, and combined with, those stated under <i>Habilitative Services and Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</i>.</p> <p><i>All Other Services</i></p> <p>Visit limits above do not include any service which is billed only for the administration of intravenous infusion.</p> <p>Visit limits above do not apply for the treatment of Mental Illness and substance-related and addictive disorders.</p> <p>In addition to the Co-payment stated in this section, you will also be responsible for the Co-payment stated under the <i>Enteral Nutrition and Prescribed Donor Milk</i> Benefit for enteral formulas and low protein modified food products.</p> | <p><i>Rehabilitative/Habilitative Services provided in the Home</i></p> <p>\$50 per visit</p> <p><i>Home Health Care Visit for Enteral Feeding</i></p> <p>\$50 per visit</p> <p><i>Home Health Care Visit for All Other Services</i></p> <p>\$50 per visit</p> | <p>Yes</p> <p>Yes</p> <p>Yes</p> | |
| | <p><i>Out-of-Network</i></p> <p><i>Rehabilitative/Habilitative Services provided in the Home</i></p> <p>\$100 per visit</p> <p><i>Home Health Care Visit</i></p> | <p>Yes</p> | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| | <i>for Enteral Feeding</i> | | |
| | \$100 per visit | Yes | |
| | <i>Home Health Care Visit for All Other Services</i> | | |
| | \$100 per visit | Yes | |
| 14. Hospice Care | | | |
| <p align="center">Prior Authorization Requirement</p> <p>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, you will be responsible for paying all charges and no Benefits will be paid.</p> <p>In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p> | | | |
| | Network | | |
| | <i>Home Visit</i> | | |
| | \$90 per visit | Yes | |
| | <i>Inpatient</i> | | |
| | \$4,500 per Inpatient Stay | Yes | |
| | Out-of-Network | | |
| | <i>Home Visit</i> | | |
| | \$270 per visit | Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---------------------------------|---|--|
| | <i>Inpatient</i> | | |
| | \$13,000 per Inpatient Stay | Yes | |

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, 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 admissions or as soon as is reasonably possible for non-scheduled admissions.

| | | | |
|---|--------------------------------------|-----|--|
| Note: Returning home with Durable Medical Equipment, such as crutches, following an inpatient Hospital admission may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i> . | Network | | |
| | <i>Level 3 Procedure</i> | | |
| | *\$400 to \$5,500 per Inpatient Stay | Yes | |
| | <i>Level 4 Procedure</i> | | |
| | *\$400 to \$5,500 per Inpatient Stay | Yes | |
| | <i>Level 5 Procedure</i> | | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| | *\$2,600 to \$5,500 per Inpatient Stay | Yes | |
| | <i>All Other Inpatient Stays</i> | Yes | |
| | \$4,500 per Inpatient Stay | | |
| | <i>Out-of-Network</i> | | |
| | <i>Level 3 Procedure</i> | | |
| | **\$13,000 per visit | Yes | |
| | <i>Level 4 Procedure</i> | | |
| | **\$13,000 per Inpatient Stay | Yes | |
| | <i>Level 5 Procedure</i> | | |
| | **\$13,000 per visit | Yes | |
| | <i>All Other Inpatient Stays</i> | Yes | |
| | \$13,000 per Inpatient Stay | | |
| 16. Lab, X-Ray and Diagnostic - Outpatient | | | |
| Prior Authorization Requirement | | | |
| For Out-of-Network Benefits for Genetic Testing, including BRCA testing, and sleep studies, you must | | | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. | | | |
| Lab Testing - Outpatient | Network | | |
| | <i>Genetic Testing, other than BRCA</i> | | |
| | \$400 per visit | Yes | |
| | <i>Allergy Testing</i> | | |
| | \$275 per visit | Yes | |
| | <i>All Other Lab Testing, including BRCA</i> | | |
| | None per visit | Yes | |
| | | | |
| | Out-of-Network | | |
| | <i>Genetic Testing, other than BRCA</i> | | |
| | \$1,200 per visit | Yes | |
| | <i>Allergy Testing</i> | | |
| | \$800 per visit | Yes | |
| | <i>All Other Lab Testing, including BRCA</i> | | |
| | None per visit | Yes | |
| | | | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|---|---|--|
| X-Ray and Diagnostic Ultrasound - Outpatient If imaging is performed on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, more than one Co-payment may apply. If more than one type of imaging is performed, such as an x-ray and ultrasound, on the same date of service, more than one Co-payment may apply. | Network None per visit | Yes | |
| | Out-of-Network None per visit | Yes | |
| All Other Diagnostic Testing - Outpatient If more than one type of diagnostic testing is performed, such as an EKG exercise stress test and an electroencephalogram (EEG), on the same date of service, more than one Co-payment may apply. | Network <i>Transesophageal Echocardiogram</i> *\$900 to \$2,500 per visit <i>Sleep Study - Home</i> \$130 per visit <i>Sleep Study - Facility</i> \$200 to \$1,100 per visit | Yes Yes Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | <i>Angiography (Arteriography)</i> *\$650 to \$1,800 per visit <i>Coronary Calcium Score (Heart Scan)</i> *\$60 to \$110 per visit <i>All Other Diagnostic Testing - Outpatient</i> *\$40 to \$1,000 per visit | Yes Yes Yes | |
| | <i>Out-of-Network</i> <i>Transesophageal Echocardiogram</i> \$7,500 per visit <i>Sleep Study - Home</i> \$390 per visit <i>Sleep Study - Facility</i> \$3,300 per visit <i>Angiography (Arteriography)</i> **\$5,400 per visit <i>Coronary Calcium Score</i> | Yes Yes Yes Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| | (Heart Scan) | | |
| | **\$330 per visit | Yes | |
| | All Other Diagnostic Testing - Outpatient | | |
| | **\$3,000 per visit | Yes | |
| 17. Major Diagnostic and Imaging - Outpatient | | | |
| <p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for CT, PET scans, MRI, MRA, angiography, and 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, you will be responsible for paying all charges and no Benefits will be paid.</p> | | | |
| <p>If imaging is performed on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, more than one Co-payment may apply.</p> <p>If more than one type of imaging is performed, such as an MRI and CT scan, on the same date of service, more than one Co-payment may apply.</p> | <p>Network</p> <p>*\$200 to \$1,150 per visit</p> | Yes | |
| | <p>Out-of-Network</p> <p>**\$3,450 per visit</p> | Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|---------------------------------|---|--|
| | | | |
| 18. 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/High Intensity Outpatient; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

| | | | |
|--|----------------------------------|-----|--|
| | Network | | |
| | <i>Inpatient Hospital</i> | | |
| | \$4,500 per Inpatient Stay | Yes | |
| | <i>Residential Treatment</i> | | |
| | \$3,500 per Inpatient Stay | Yes | |
| | <i>Outpatient</i> | | |
| | <i>Office Visit - In-Person</i> | | |
| | \$45 per visit | Yes | |
| | <i>Office Visit - Telehealth</i> | | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | \$45 per visit <i>Biofeedback</i> | Yes | |
| | \$45 per visit <i>Applied Behavioral Analysis (ABA)</i> | Yes | |
| | \$45 per visit <i>E-Visit/Telephone Visit</i> | Yes | |
| | \$45 per visit <i>Substance-Related and Addictive Disorders Medication Management</i> | Yes | |
| | \$15 per visit <i>Partial Hospitalization/Day Treatment/High Intensity Outpatient</i> | Yes | |
| | \$200 per visit <i>Electroconvulsive Therapy</i> | Yes | |
| | \$200 per visit <i>Intensive Outpatient Treatment</i> | Yes | |

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | \$110 per visit <i>Outpatient Alcohol and Drug Treatment Program</i> | Yes | |
| | \$200 per visit <i>Transcranial Magnetic Stimulation (TMS) Therapy</i> | Yes | |
| | \$190 per visit <i>All Other Outpatient Services</i> | Yes | |
| | \$200 per visit | Yes | |
| | <i>Out-of-Network</i> <i>Inpatient Hospital</i> \$13,000 per Inpatient Stay | Yes | |
| | <i>Residential Treatment</i> \$10,500 per Inpatient Stay | Yes | |
| | <i>Outpatient Office Visit - In-Person</i> \$235 per visit | Yes | |
| | <i>Office Visit - Telehealth</i> \$235 per visit | Yes | |
| | <i>Biofeedback</i> \$235 per visit | 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 *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---|---|--|
| | <i>Applied Behavioral Analysis (ABA)</i> \$235 per visit | Yes | |
| | <i>E-Visit/Telephone Visit</i> \$465 per visit | Yes | |
| | <i>Substance-Related and Addictive Disorders Medication Therapy</i> \$45 per visit | Yes | |
| | <i>Partial Hospitalization/Day Treatment/High Intensity Outpatient</i> \$600 per visit | Yes | |
| | <i>Electroconvulsive Therapy</i> \$600 per visit | Yes | |
| | <i>Intensive Outpatient Treatment</i> \$330 per visit | Yes | |
| | <i>Outpatient Alcohol and Drug Treatment Program</i> \$500 per visit | Yes | |
| | <i>Transcranial Magnetic Stimulation (TMS) Therapy</i> \$570 per visit | Yes | |
| | <i>All Other Outpatient Services</i> | Yes | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---------------------------------|---|--|
| | \$600 per visit | | |

19. Palliative Care

| | |
|---|--|
| <p>Note: Returning home with Durable Medical Equipment, such as a walker, following palliative care may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i>.</p> | <p>Network</p> <p>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 <i>Schedule of Benefits</i>.</p> |
| | <p>Out-of-Network</p> <p>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 <i>Schedule of Benefits</i>.</p> |

20. Pharmaceutical Products - Outpatient

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization five business days before scheduled intravenous infusions 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, you will be responsible for paying all charges and no Benefits will be paid.

For Out-of-Network Benefits, you must obtain prior authorization five business days before certain Pharmaceutical Products 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, you will be responsible for

| | | | |
|---|--|--|--|
| 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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount. | | | |
| <p>*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.</p> <p>**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.</p> | | | |
| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
| paying all charges and no Benefits will be paid. You may find out whether a particular Pharmaceutical Product requires prior authorization by visiting benefits.surest.com or calling the telephone number on your ID card. | | | |
| | Network *\$80 to \$4,200 per visit | Yes | |
| | Out-of-Network \$12,600 per visit | Yes | |
| 21. Physician's Office Services - Sickness and Injury | | | |
| <p>Note: Returning home with Durable Medical Equipment, such as crutches, following an office visit may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i>.</p> <p>In addition to the Co-payment stated in this section, the Co-payment for following services also apply when the Covered Health Care Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostic - Outpatient</i>. Major diagnostic and nuclear | <p>Network</p> <p><i>Primary Care Physician/Specialist Office Visit - In-Person</i></p> <p>*\$45 to \$155 per visit</p> <p><i>Telehealth Visit</i></p> <p>*\$45 to \$155 per visit</p> <p><i>Visit in the Home</i></p> <p>\$90 per visit</p> <p><i>Convenience Care/Retail</i></p> <p>\$50 per visit</p> <p><i>Allergy Injections</i></p> <p>None per visit</p> | <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| <p>medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>.</p> <ul style="list-style-type: none"> Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. Certain outpatient surgery procedures described under <i>Surgery - Outpatient</i>. Certain outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. <p>Note: When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing whether performed in or out of the Physician's office will apply additional cost sharing as described above.</p> | <p><i>Biofeedback</i></p> <p>\$80 per visit</p> <p><i>E-Visit/Telephone Visit</i></p> <p>\$45 per visit</p> <p><i>Anticoagulant Management</i></p> <p>\$30 per visit</p> | <p>Yes</p> <p>Yes</p> <p>Yes</p> | |
| | <p><i>Out-of-Network</i></p> <p><i>Primary Care Physician/Specialist</i></p> | | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | <i>Office Visit In-Person</i> | | |
| | \$465 per visit | Yes | |
| | <i>Telehealth Visit</i> | | |
| | \$465 per visit | Yes | |
| | <i>Visit in the Home</i> | | |
| | \$270 per visit | Yes | |
| | <i>Convenience Care/Retail</i> | | |
| | Out-of-Network Benefits are not available. | Out-of-Network Benefits are not available. | |
| | <i>Allergy Injections</i> | | |
| | \$235 per visit | Yes | |
| | <i>Biofeedback</i> | | |
| | \$240 per visit | Yes | |
| | <i>E-Visit/Telephone Visit</i> | | |
| | \$465 per visit | Yes | |
| | <i>Anticoagulant Management</i> | | |
| | \$90 per visit | Yes | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---------------------------------|---|--|
|-----------------------------|---------------------------------|---|--|

22. Pregnancy - Maternity Services

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, you will be responsible for paying all charges and no Benefits will be paid.

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

| | | | |
|---|--|-----|--|
| Note: Returning home with Durable Medical Equipment, such as a fetal monitor, following an office visit or inpatient admission may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i> . | Network | | |
| | <i>Routine Prenatal and Postnatal Care</i> | | |
| | None per visit | Yes | |
| | <i>Amniocentesis</i> | | |
| | \$1,000 per test | Yes | |
| | <i>Chorionic Villus Sampling (CVS)</i> | | |
| | \$1,300 per test | Yes | |
| | <i>Home Birth</i> | | |
| | \$1,800 per delivery | Yes | |
| | <i>Inpatient Delivery</i> | | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? |
|--|--|--|
| | *\$2,500 to \$4,500 per Inpatient Stay, except that if a newborn stays in the Hospital longer than the mother, an additional Co-payment will apply for the newborn Inpatient Stay. | Yes |
| <p><i>All Other Services</i></p> <p>Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> | | |
| | <p><i>Out-of-Network</i></p> <p><i>Routine Prenatal and Postnatal Care</i></p> <p>\$235 per visit</p> <p><i>Amniocentesis</i></p> <p>\$3,000 per test</p> <p><i>Chorionic Villus Sampling (CVS)</i></p> <p>\$3,500 per test</p> <p><i>Home Birth</i></p> <p>\$5,400 per delivery</p> <p><i>Inpatient Delivery</i></p> | <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|---|---|--|
| | \$13,000 per Inpatient Stay, except that if a newborn stays in the Hospital longer than the mother, an additional Co-payment will apply for the newborn Inpatient Stay. | Yes | |
| | <i>All Other Services</i> Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . | | |
| 23. Preimplantation Genetic Testing (PGT) and Related Services | | | |
| Benefit limits for related services will be the same as, and combined with, those stated under <i>Fertility Preservation for Iatrogenic Infertility</i> . This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug Rider</i> . Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include Preimplantation Genetic Testing (PGT) | Network \$500 per visit | Yes | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|--|---|--|
| for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug Rider</i> . | | | |
| | Out-of-Network Out-of-Network Benefits are not available. | Out-of-Network Benefits are not available. | |
| 24. Preventive Care Services | | | |
| Physician office services | Network None | No | |
| | Out-of-Network \$235 per visit | Yes | |
| Lab, X-ray or other preventive tests | Network None | No | |
| | Out-of-Network <i>Major Diagnostic Imaging</i> \$3,450 per visit <i>All Other Services</i> None per service | Yes Yes | |
| Breast pumps | Network | | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | None | No | |
| | Out-of-Network Benefits will be the same as stated under <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> in this <i>Schedule of Benefits</i> . | | |

25. 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, 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 or as soon as is reasonably possible for non-scheduled inpatient admissions.

| | |
|--|---|
| <p>Note: Returning home with Durable Medical Equipment, such as a walker, following a reconstructive procedure may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i>.</p> | <p>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 <i>Schedule of Benefits</i>.</p> |
|--|---|

| | | | |
|--|--|--|--|
| 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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount. | | | |
| <p>*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.</p> <p>**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.</p> | | | |
| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
| | <p><i>Out-of-Network</i> 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 <i>Schedule of Benefits</i>.</p> | | |
| 26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment | | | |
| <p>Limited per year as follows:</p> <ul style="list-style-type: none"> 60 visits of physical therapy. 60 visits of occupational therapy and cognitive rehabilitation therapy combined. 60 visits of speech therapy. <p>Visits limits above for Manipulative Treatment, physical therapy, occupational therapy, and speech therapy do not apply for the treatment of Mental Illness or substance-related and addictive disorders.</p> <p>Note: Returning home with Durable Medical Equipment, such as a walker, following rehabilitation therapy may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i>.</p> | <p><i>Network</i></p> <p><i>Manipulative Treatment</i> \$40 per visit</p> <p><i>Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> \$35 per visit</p> <p><i>Occupational Therapy for All Other Conditions</i> *\$35 to \$140 per visit</p> <p><i>Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> \$35 per visit</p> <p><i>Physical Therapy for All Other Conditions</i></p> | <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---|---|--|
| | *\$35 to \$110 per visit <i>Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> | Yes | |
| | \$35 per visit <i>Speech Therapy for All Other Conditions</i> | Yes | |
| | *\$35 to \$140 per visit <i>Pulmonary Rehabilitation Therapy</i> | Yes | |
| | *\$100 per visit <i>Cardiac Rehabilitation Therapy</i> | Yes | |
| | *\$110 per visit <i>Post-cochlear Implant Aural Therapy</i> | Yes | |
| | *\$60 to \$150 per visit <i>Cognitive Rehabilitation Therapy</i> | Yes | |
| | *\$35 to \$140 per visit | Yes | |
| | <i>Out-of-Network Manipulative Treatment</i> \$120 per visit <i>Occupational Therapy</i> | Yes | |

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---|---|--|
| | <i>for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> | | |
| | \$105 per visit | Yes | |
| | <i>Occupational Therapy for All Other Conditions</i> | | |
| | \$420 per visit | Yes | |
| | <i>Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> | | |
| | \$105 per visit | Yes | |
| | <i>Physical Therapy for All Other Conditions</i> | | |
| | \$330 per visit | Yes | |
| | <i>Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> | | |
| | \$105 per visit | Yes | |
| | <i>Speech Therapy for All Other Conditions</i> | | |
| | \$420 per visit | Yes | |
| | <i>Pulmonary Rehabilitation Therapy</i> | | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|---|---|--|
| | \$300 per visit <i>Cardiac Rehabilitation Therapy</i> | Yes | |
| | \$330 per visit <i>Post-cochlear Implant Aural Therapy</i> | Yes | |
| | \$450 per visit <i>Cognitive Rehabilitation Therapy</i> | Yes | |
| | \$420 per visit | Yes | |
| 27. Scopic Procedures - Outpatient Diagnostic and Therapeutic | | | |
| <p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, 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, you will be responsible for paying all charges and no Benefits will be paid.</p> | | | |
| | Network | | |
| | <i>Level 1 Procedure</i> | | |
| | *\$80 to \$5,000 per visit | Yes | |
| | <i>Level 2 Procedure</i> | | |
| | *\$125 to \$5,500 per visit | Yes | |
| | <i>Level 3 Procedure</i> | | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | *\$400 to \$5,500 per visit <i>All Other Procedures</i> | Yes | |
| | *\$300 to \$1,300 per visit | Yes | |
| | <i>Out-of-Network</i> <i>Level 1 Procedure</i> **\$13,000 per visit <i>Level 2 Procedure</i> **\$13,000 per visit <i>Level 3 Procedure</i> **\$13,000 per visit <i>All Other Procedures</i> \$3,900 per visit | Yes Yes Yes Yes | |

28. 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, 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 *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| 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. | | | |
| <p>Limited to:</p> <ul style="list-style-type: none"> 120 days per year in a Skilled Nursing Facility. Covered Health Care Services in an Inpatient Rehabilitation Facility are not subject to an annual limit. <p>Note: Returning home with Durable Medical Equipment, such as a walker, following an admission may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i>.</p> | <p>Network</p> <p><i>Skilled Nursing Facility</i></p> <p>\$3,500 per Inpatient Stay</p> <p><i>Inpatient Rehabilitation Facility</i></p> <p>\$3,500 per Inpatient Stay</p> | <p>Yes</p> <p>Yes</p> | |
| | <p>Out-of-Network</p> <p><i>Skilled Nursing Facility</i></p> <p>\$10,500 per Inpatient Stay</p> <p><i>Inpatient Rehabilitation Facility</i></p> <p>\$10,500 per Inpatient</p> | <p>Yes</p> <p>Yes</p> | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|---------------------------------|---|--|
| | Stay | | |
| 29. Surgery - Outpatient | | | |
| <p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for all outpatient surgeries, 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, you will be responsible for paying all charges and no Benefits will be paid.</p> | | | |
| <p>Note: Returning home with Durable Medical Equipment, such as crutches, following an outpatient surgery may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i>.</p> | Network | | |
| | <i>Level 1 Procedure</i> | | |
| | *\$80 to \$5,000 per visit | Yes | |
| | <i>Level 2 Procedure</i> | | |
| | *\$125 to \$5,500 per visit | Yes | |
| | <i>Level 3 Procedure</i> | | |
| | *\$400 to \$5,500 per visit | Yes | |
| | <i>All Other Procedures</i> | | |
| | *\$300 to \$1,300 per visit | Yes | |
| | Out-of-Network | | |
| | <i>Level 1 Procedure</i> | | |
| | **\$13,000 per visit | Yes | |
| | <i>Level 2 Procedure</i> | | |

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*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.

**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|---|---|--|
| | **\$13,000 per visit <i>Level 3 Procedure</i> | Yes | |
| | **\$13,000 per visit <i>All Other Procedures</i> | Yes | |
| | \$3,900 per visit | Yes | |
| 30. Temporomandibular Joint (TMJ) Services and Orthognathic Surgery | | | |
| <p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, you must obtain prior authorization five business days before TMJ or orthognathic surgery services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p> <p>In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.</p> | | | |
| Note: Returning home with Durable Medical Equipment, such as an oral appliance, following orthognathic surgery may result in an additional Co-payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i> . | <p>Network</p> <p><i>Orthognathic Surgery</i></p> <p>\$5,000 per Inpatient Stay</p> <p><i>All Other Services</i></p> <p><i>Inpatient</i></p> <p>\$4,500 per Inpatient Stay</p> <p><i>Outpatient Office Visit</i></p> | <p>Yes</p> <p>Yes</p> | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|--|---|--|
| | *\$45 to \$155 per visit <i>Outpatient Hospital</i> | Yes | |
| | *\$300 to \$1,300 per visit | Yes | |
| | <i>Out-of-Network</i> <i>Orthognathic Surgery</i> \$13,000 per Inpatient Stay <i>All Other Services</i> <i>Inpatient</i> \$13,000 per Inpatient Stay <i>Outpatient Office Visit</i> \$465 per visit <i>Outpatient Hospital</i> \$3,900 per visit | Yes Yes Yes Yes | |

31. Therapeutic Treatments - Outpatient

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization for all 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. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---|---|--|
| | Network | | |
| | <i>Dialysis - Home</i> | | |
| | *\$225 per visit | Yes | |
| | <i>Dialysis - All Other Settings</i> | | |
| | *\$150 to \$625 per visit | Yes | |
| | <i>Apherisis</i> | | |
| | *\$270 to \$510 per visit | Yes | |
| | <i>Hyperbaric Oxygen Therapy</i> | | |
| | *\$550 to \$1,125 per visit | Yes | |
| | <i>Chemotherapy</i> | | |
| | *\$70 to \$775 per visit | Yes | |
| | <i>Radiation Oncology</i> | | |
| | *\$110 to \$3,200 per visit | Yes | |
| | <i>Blood Transfusion</i> | | |
| | *\$350 to \$2,200 per visit | Yes | |
| | <i>Non-Oral Radiopharmaceutical Therapy</i> | | |

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[illegible]

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|---|---|--|
| | \$6,600 per visit <i>Non-Oral Radiopharmaceutical Therapy</i> | Yes | |
| | \$13,000 per visit <i>Oral Radiopharmaceutical Therapy</i> | Yes | |
| | \$9,600 per visit | Yes | |
| 32. Transplantation Services | | | |
| 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 <i>Schedule of Benefits</i> . | | |
| | Out-of-Network Out-of-Network Benefits are not available. | | |
| 33. Urgent Care Center Services | | | |
| Note: Returning home with Durable Medical Equipment, such as a crutches, following an urgent care visit may result in an additional Co- | Network \$110 per visit | Yes | |

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| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|--|--|
| payment. Co-payments will be dependent on the tier the item is assigned to. Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, Supplies and Prosthetic Services</i> category in this <i>Schedule of Benefits</i> . | | | |
| | Out-of-Network \$330 per visit | Yes | |
| 34. Virtual Care Services | | | |
| Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by visiting benefits.surest.com or calling the telephone number on your ID card. | Network <i>Primary Care</i> None per visit <i>Urgent Care</i> None per visit <i>Specialty Care</i> *\$35 to \$155 per visit <i>Mental Health</i> *\$45 to \$110 per visit | Yes Yes Yes Yes | |
| | Out-of-Network Out-of-Network Benefits are not available. | Out-of-Network Benefits are not | |

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---------------------------------|---|--|
| | | available. | |

35. Vision Exams

| | | | |
|-------------------------------|--|-----|--|
| Limited to 1 exam every year. | Network None per visit | Yes | |
| | Out-of-Network \$465 per visit | Yes | |

Additional Benefits Required By Louisiana Law

36. Attention Deficit Disorder Services

Prior Authorization Requirement

For Out-of-Network Benefits, depending upon where the Covered Health Care Service is provided, any applicable 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 <i>Schedule of</i> | Yes | |
|--|--|-----|--|

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|---|---|--|
| | <i>Benefits.</i> | | |
| | <i>Out-of-Network</i> 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 <i>Schedule of Benefits</i> . | Yes | |
| 37. Autism Spectrum Disorders Treatment Services | | | |
| Prior Authorization Requirement For Out-of-Network Benefits, depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . | | | |
| | <i>Network</i> 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 <i>Schedule of Benefits</i> . | Yes | |
| | <i>Out-of-Network</i> Depending upon where | Yes | |

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 You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|--|---|--|
| | the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . | | |
| 38. Bilateral Mastectomy Cancer Screening | | | |
| | 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 <i>Schedule of Benefits</i> . | Yes | |
| | 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 <i>Schedule of Benefits</i> . | Yes | |
| 39. Cleft Lip and Cleft Palate Services | | | |

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 You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--|---|---|--|
| <p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> | | | |
| <p>Benefits for amplification devices that meet the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment (DME), Orthotics and Supplies.</p> <p>Benefits for oral-related prosthetic devices are not subject to the limit stated under Prosthetic Devices, Supplies and Prosthetic Services.</p> | <p>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 <i>Schedule of Benefits</i>.</p> | Yes | |
| | <p>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 <i>Schedule of Benefits</i>.</p> | Yes | |
| 40. Dental Services - Hospitalization and General Anesthesia | | | |

Prior Authorization Requirement

For Out-of-Network Benefits, depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health

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 *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|---|--|---|--|
| Care Service category in this <i>Schedule of Benefits</i> . | | | |
| | 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 <i>Schedule of Benefits</i> . | Yes | |
| | 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 <i>Schedule of Benefits</i> . | Yes | |
| 41. Qualified Interpreter/Translator Services | | | |
| | 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 | 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 *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|--------------------------------|---|---|--|
| | this <i>Schedule of Benefits</i> . | | |
| | <i>Out-of-Network</i> 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 <i>Schedule of Benefits</i> . | Yes | |
| 42. Telehealth Services | | | |
| | <i>Network</i> 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 <i>Schedule of Benefits</i> . | Yes | |
| | <i>Out-of-Network</i> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health | 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 *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

| Covered Health Care Service | What Is the Co-payment You Pay? | Does the Amount You Pay Apply to the Out-of-Pocket Limit? | |
|-----------------------------|---|---|--|
| | Care Service category in this <i>Schedule of Benefits</i> . | | |

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 which is based on the Recognized Amount as defined in the *Certificate*.
 - ***For Covered Health Care Services that are non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment which is based on the Recognized Amount as defined in the *Certificate*.
 - For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the Recognized Amount as defined in the *Certificate*.
 - For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the rates that

would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

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

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-payment. 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, (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), 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 which is based on the Recognized Amount as defined in the *Certificate*.

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

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the Recognized Amount as defined in the *Certificate*.

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

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

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

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

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 100% 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*.
 - ♦ 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 visiting benefits.surest.com or calling the telephone number on your ID card. A directory of providers is available by visiting benefits.surest.com or calling 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) 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 you are currently seeing a Network provider and that 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 or healthcare facility 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 care, such as serious and complex conditions including Life-Threatening Illness, institutional or inpatient care, nonelective surgery, high-risk pregnancy or pregnancy past the twenty-fourth week and terminal illness; and timeframes, such as the earlier of 90 days or the date on which you are no longer a continuing care patient, as defined and described in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*. 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. 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.

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. For assistance visit benefits.surest.com or call the telephone number on your ID card.

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.

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.

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 a Network Pharmacy and are subject to Co-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.

Benefits for Oral Chemotherapeutic Agents

For oral chemotherapeutic agents, the total amount of any applicable deductibles, Co-payments or Co-insurance shall not exceed \$100 for an individual prescription of up to a 31-day supply, regardless of tier placement. To comply with federal law, a high deductible health plan will need to meet the deductible before the cost-sharing cap will apply.

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 may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product. We will not remove or change the tier placement of Prescription Drug Products from our Prescription Drug List (PDL) more often than annually and only on the Policy anniversary date.

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 may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference 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, 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 visiting benefits.surest.com or calling 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.

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 prior authorization by visiting benefits.surest.com or calling the telephone number on your ID card.

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

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, less the required Co-payment and Ancillary Charge. 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 visiting benefits.surest.com or calling 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. However, you or your prescriber may request an override exception and we will provide determination no later than 72 hours after receipt of the request for the step therapy override exception. An expedited exception request will be reviewed with a determination provided no later than 24 hours following the request.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by visiting benefits.surest.com or calling the telephone number on your ID card.

In the case of drugs for the treatment of stage IV advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with at least one of the following:

- Use consistent with the FDA approved indication,

- Has the *National Comprehensive Cancer Network Drugs and Biologics Compendium Indication*, or
- Is supported by peer-reviewed, evidence-based medical literature.

Using appropriate clinical evidence, your provider may request a step therapy review or an override of the step therapy requirements if:

- The preferred treatment required, or another prescription drug in the same pharmacologic class or with the same mechanism of action under the step therapy requirements has been ineffective in the treatment of your disease or medical condition.
- The preferred treatment required under the step therapy requirements is reasonably expected to be ineffective based on your known relevant physical or mental characteristics and medical history and known characteristics of the drug regimen.
- The preferred treatment required under the step therapy requirements will cause, is contraindicated or will likely cause an adverse reaction or other physical or mental harm to you.
- You are currently receiving a positive therapeutic outcome on a non-preferred treatment for the medical condition under consideration if, while on your current plan or the immediately preceding health coverage plan, you received coverage for the non-preferred drug.
- The preferred treatment is not in your best interest based on medical necessity as evidenced by valid documentation submitted by your provider.

An approval or denial of a step therapy or override request will be determined within:

- For non-urgent step therapy requests, a review will be completed within seventy-two (72) hours once all information needed to process the request has been received.
- For urgent step therapy requests, a review will be completed within twenty-four (24) hours once all the information needed to process the request has been received.
- If we fail to comply with the timelines noted above, the request will be considered approved. You may appeal a denial of step therapy or override request. Please see *Section 6: Questions, Complaints and Appeals*.

What Do You Pay?

You are responsible for paying the applicable Co-payment described in the Benefit Information table in addition to any Ancillary Charge. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment for Prescription Drug Products on the List of Zero Cost Share Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is Chemically Equivalent.

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 *Certificate*:

- Ancillary Charges.
- Any amount you pay for Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) that exceeds the Maximum Policy Benefit.
- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- 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 |
|--|---|
| Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) Maximum Policy Benefit | |
| The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy. | \$5,000 per Covered Person. |
| Co-payment | |
| <p>Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.</p> <p>Your Co-payment is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Co-payment 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 by visiting benefits.surest.com or calling the telephone number on your ID card.</p> <p>Your Co-payment 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 associated with such programs by visiting benefits.surest.com or calling the telephone number on your ID card.</p> <p>Your Co-payment for insulin will not exceed the amount allowed by applicable law.</p> <p>For insulin drugs the total amount of Co-payments shall not exceed \$75 for an individual prescription of up to a 30-day supply.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Co-payment based on your condition and/or 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</p> | <p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>Covered Persons may be subject to an excess consumer cost burden when Prescription Drug Products are purchased under this Rider.</p> <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Co-payments stated in the <i>Benefit Information</i> table for amounts.</p> <p>You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.</p> <p>You are not responsible for paying a Co-payment for Prescription Drug Products on the List of Zero Cost Share Medications.</p> |

| Payment Term and Description | Amounts |
|--|---------|
| <p>visiting benefits.surest.com or calling the telephone number on your ID card.</p> <p>NOTE: We will not remove or change the tier placement of Prescription Drug Products from our Prescription Drug List (PDL) more often than annually and only on the Policy anniversary date.</p> <p>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 may vary when you use a coupon. Contact benefits.surest.com or the telephone number on your ID card for an available list of Specialty Prescription Drug Products and the applicable Co-payment.</p> <p>NOTE: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly 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 visit benefits.surest.com or call the telephone number on your ID card for the most up-to-date tier status.</p> <p>Prescription Drug Products Prescribed by a Specialist: You may receive a reduced or increased Co-payment 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 by contacting us at benefits.surest.com or the telephone number on your ID card.</p> <p>Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment.</p> | |

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.

| Description and Supply Limits | What Is the Co-payment You Pay? |
|--|--|
| Specialty Prescription Drug Products | |
| <p>The following supply limits apply.</p> <ul style="list-style-type: none"> 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. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment that applies will reflect the number of days dispensed or days the drug will be delivered.</p> <p>If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy or a Designated Pharmacy.</p> | <p>Your Co-payment 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 visit benefits.surest.com or call the telephone number on your ID card to find out tier placement.</p> <p>For a Tier 1 Specialty Prescription Drug Product: \$20 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: \$150 per Prescription Order or Refill.</p> |
| Prescription Drugs from a Retail Network Pharmacy | |
| <p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. For contraceptives a one-cycle supply is allowed. However, the Covered Person may obtain up to three (3) cycles at one time if the Covered Person pays a Drug Co-payment for each cycle supplied. When a Covered Person chooses a method outside the preventive care drug list, a Drug Co-payment will be charged. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more</p> | <p>Your Co-payment 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 visit benefits.surest.com or call the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: \$20 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$90 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$150 per Prescription Order or Refill.</p> |

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.

| Description and Supply Limits | What Is the Co-payment You Pay? |
|---|---|
| than a consecutive 30-day supply, the Co-payment that applies will reflect the number of days dispensed or days the drug will be delivered. | |
| Prescription Drug Products from a Mail Order Network Pharmacy or a Retail Network Pharmacy | |
| <p>The following supply limits apply:</p> <ul style="list-style-type: none"> 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 or a retail Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>. <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or a 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.</p> | <p>Your Co-payment 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 visit benefits.surest.com or call the telephone number on your ID card to find out tier status.</p> <p>For up to a 30-day supply at a mail order Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$20 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$90 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For up to a 60-day supply at a mail order Network Pharmacy or a retail Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$40 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$180 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For up to a 90-day supply at a mail order Network Pharmacy or a retail Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$50 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$225 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$375 per Prescription Order or Refill.</p> |

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 *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

UnitedHealthcare Insurance Company

A handwritten signature in cursive script that reads "Jessica Paik".

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 periodically change the placement of a Prescription Drug Product among the tiers. These changes will occur no more often than annually on the Policy anniversary date.

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.

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 visit benefits.surest.com or call 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 Surest 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 Surest 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 *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not 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 Ancillary Charge.

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 are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

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. 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 visiting benefits.surest.com or calling 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. 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.

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.

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 visiting benefits.surest.com or calling 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 to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the mail order Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at benefits.surest.com or the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and 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.

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.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

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

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.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

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

Please visit benefits.surest.com or call 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.

Section 2: Exclusions

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

When an exclusion applies to only certain Prescription Drug Products, you can visit benefits.surest.com or call the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not include a Prescription Drug Product that has been prescribed for a specific type of cancer for which the medication has not yet been approved by the *U.S. Food and Drug Administration*. This medication must be recognized for a specific type of cancer in a standard reference compendia or in a substantially accepted peer-reviewed medical literature. This exclusion does not include a Prescription Drug Product that has been prescribed for metastatic or unresectable tumors if the drug is approved by the U.S Food and Drug Administration for the treatment of cancers with specific mutations, the patient's cancer has been determined to contain the specific mutation, and there is no alternative treatment, or the patient has contraindication to the alternative treatment, that has proven to be more effective in published randomized clinical trials. Coverage for the treatment of metastatic cancer or unresectable tumors will be for an initial trial of 3 months of therapy and will continue providing that the treating physician certifies that the drug is Medically Necessary based on documented improvement of the patient.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Any product dispensed for the purpose of appetite suppression or weight loss.
11. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies *and Prosthetic Services*. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.

- Vitamins with fluoride.
 - Single entity vitamins.
13. Certain unit dose packaging or repackagers of Prescription Drug Products.
 14. Medications used for cosmetic or convenience purposes.
 15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
 16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
 17. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the *Certificate*.
 18. Certain Prescription Drug Products for tobacco cessation.
 19. 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.)
 20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations will occur no more often than annually on the Policy anniversary date. 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 covered under the PPACA Zero Cost Share Preventive Care Medications which includes over-the-counter tobacco cessation products. Please see the PPACA Zero Cost Share Preventive Care Medications definition under *Section 3: Defined Terms*.
 21. 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.
 22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
 23. 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.
 24. A particular Therapeutic Class or Therapeutic Classes. Please contact us at benefits.surest.com or the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.
 25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
 26. 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 will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
28. Certain Prescription Drug Products that have not been prescribed by a Specialist.
29. A Prescription Drug Product that contains marijuana, including medical marijuana.
30. Dental products, including but not limited to prescription fluoride topicals.
31. 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 will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

32. Diagnostic kits and products, including associated services.
33. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
34. 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, that you must pay when a covered Prescription Drug Product is dispensed at your 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.

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.

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) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at benefits.surest.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 visiting benefits.surest.com or calling the telephone number on your ID card.

Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our review and change from time to time and varies by Therapeutic Class.

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 Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

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,) 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*, including tobacco cessation products.
- Certain immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

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 visiting benefits.surest.com or calling the telephone number on your ID card.

Preferred Retail Network Pharmacy - a retail 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)*. These changes will occur no more often than annually on the Policy anniversary date. You may find out to which tier a particular Prescription Drug Product has been placed by visiting benefits.surest.com or calling the telephone number on your ID card for the most up-to-date tier placement.

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.
- 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; and
- glucose meters, including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice 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*. You may access a complete list of Specialty Prescription Drug Products by visiting benefits.surest.com or calling the telephone number on your ID card.

Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.

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 Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by us, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information please visit www.uhcprovider.com under the following path: *Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act \$0 Cost-Share Preventive Medications Exemption Requests (Commercial Members)*.

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 Co-payments 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 18 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

Language Assistance Services

ATTENTION: If you speak **English**, free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

KUJDES: Nëse flisni **Shqip (Albanian)** shërbime falas për ndihmë gjuhësore dhe komunikime pa pagesë në formate të tjera, si p.sh. printime me shkronja të mëdha, janë të disponueshme për ju. Telefononi numrin pa pagesë në kartën tuaj të identifikimit të anëtarit.

ማሳሰቢያ፡- አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ አትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ቁጥርዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا كنت تتحدث اللغة العربية (Arabic)، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

ՈՒՇԱԳՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք **հայերեն (Armenian)**, սպաս ձեզ հասանելի են անվճար լեզվական և ծառայություններ և անվճար հաղորդակցություններ այլ ձևաչափերով, ինչպիսիք են մեծատառ տպագրությունը: Չանգսմանք ձեր անդամի անդամականացման քարտի վրա նշված անվճար հեռախոսահամարով:

DYÉÐÉ-GBO-DÉ-ÐÉ: M dyi **Básoó-wùdù (Bassa)** po-nyo jũ ní, wuḍu xwíníín-mú-zà-zà kè bo òḃé dé cée-dyèdè kò-kò òḃé, hwaìn-kà cée-dyèdè vèné-vèné òḃé se wídí pḗḗ-pḗḗ dò kòḗḗ nì bó m̀ bìì. Ðá pídíyì nòbà nìà nì ID káàò kòḗ.

দেখুন: আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ।

আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

သတိပေးချက်-သင်သည် ဗမာ **ဘာသာစကား (Burmese)** ကို ပြောဆိုလျှင် အခမဲ့ ဘာသာစကား ဝန်ဆောင်မှုများနှင့် စာလုံးကြီးဖြင့် ပုံနှိပ်ခြင်းကဲ့သို့ အခြားပုံစံများဖြင့် အခမဲ့ ပြောဆိုဆက်သွယ်မှုအား ရရှိနိုင်ပါသည်။ သင့်အိုင်ဒီကတ်ရှိ အခမဲ့ ဖုန်းခေါ်ဆိုခိုင်းသည့် နံပါတ်သို့ ဖုန်းခေါ်ဆိုပါ။

ចំណាំ: ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាភាគតិចផ្លែ នឹងការទំនាក់ទំនងភាគតិចផ្លែក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរស័ព្ទមកលេខភាគតិចផ្លែនៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

ATENSHUN: Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale tepangiyom. Kol yegili nampa la ye toore paliuwal woal kard la laumw.

သေဒ်SVTS: VdGy dhYCGဆဲသ **CWY** (Cherokee), dhYCGဆဲသ ဝာ်ဒုဂဆဲသ မဝံ မဲး TEZာဆဲသ
 Lh.ဆဲသဆဲသ JSSGဝံ, TS45ဝံ, D4ဆဲသ ခ်မဝံTGRY dEGG dhYCGဆဲသဆဲသ. ဝံVT TETGဆဲသT
 Jဝံဆဲသ မဆဲသ dhYCGဆဲသ မဝံ dh.ဆဲသ D4ဆဲသ ဝံVT.

請注意：如果您說中文 (**Chinese - Traditional**)，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

Asinei ngeni meinisin: Ika pwe ka fos **Chuuk (Chuukese)**, angangen aninisin fosun fonu ese wor momon me pwan kakapas fengen ese wor momon non pwan ekkoch sakkun maak kena, usun chok watten maak, ra kan kaworeno ngonuk.
Kori ewe nampa ese wor momon won noumuwe aiititin katon chon non.

توجه: اگر به زبان فارسی (Farsi) صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον χωρίς χρέωση αριθμό στην κάρτα μέλους σας.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કોલ કરો.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòm lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

MALIU MAI! Inā ‘ōlelo ‘oe i ka ‘ōlelo **Hawai‘i (Hawaiian)**, loa‘a manuahi ke kōkua unuhi a me palapala i ho‘onohono ‘ia e like me i pa‘i ‘ia me nā huapalapala nūnui no ke kōkua ‘ana aku iā ‘oe. ‘Olu‘olu e kāhea aku i ka helu kelepona kāki ‘ole ma kou kāleka lālā.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, cov kev pab cuam lus pub dawb thiab kev sib txuas lus dawb hauv lwm hom ntawv, xws li luam ntawv loj, muaj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

GEE NTI: O buru na i na-asu **asusu Igbo (Igbo)**, oru enyemaka nkowa asusu bu n'efu yana inye nziritaozi n'udi ndi ozọ diiri gi n'efu, dika e ji nha mkpuru edemede buru ibu dee ya. Kpoo akara ekwenti nke a na-anaghi akwu ugwo di na kaadi njirimara onye otu gi.

PANANGIKASO: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

PERHATIAN: Jika Anda berbicara **bahasa Indonesia (Indonesian)**, layanan bantuan bahasa gratis dan komunikasi gratis dalam format lain, seperti cetakan besar, tersedia untuk Anda. Hubungi nomor bebas pulsa yang tercantum pada kartu identifikasi keanggotaan Anda.

ATTENZIONE: Se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

注意事項：日本語（Japanese）を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。[]にお電話ください。

ဟ်သျှ်ဟ်သးတက့ၢ်-နမ့ၢ်စံးကတိၤကညိက့ၢ် (Karen)

န့ၢ်,နဒီးန့ၢ်တၢ်တိၤမၤမၤတၢ်ဘးဒီးန့ၢ်တၢ်ကတိၤဒီးတၢ်ဆဲးကျါဆဲးကျါလၢက့ၢ်ဂီၤအဂၤ,အဒိဒ်သီးလံာ်မဲၢ်ဖျါၣ် အဒိၣ်တဖၣ်လၢအဘူးလဲကလီၤသ့န့ၢ်လီၤ.ကိးဘၣ်လီၤကျါအကလီၤနီၣ်ဂံၢ်လၢအိၣ်ဖျါဖဲကရူၢ်ဖိအတၢ်အုၣ်ကီၤကးက့ၢ် အပူၤန့ၢ်တက့ၢ်.

ICITONDERWA: Nimba uyaga **Ikirundi (Kirundi)**, serevise y'ugufasha mu ndimi utariha n'itumanako mu bundi buryo, nk'ibicapo binini, wobironka. Tera akamo umuronko utariha ku bijanye n'ikarata yawe karanga y'umunyamuryango.

알림사항: 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

ئاگاداری: ئهگهر تۆ به زمانی کوردی سۆرانی (**Kurdish Sorani**) قسه دهکهیت، ئهوه خزمهتگوزاری سهبارمهت به هاوکاری زمانی و پهیوهندی به فورمهتهکانی تر، وەک چاپی گهره، به بێبهرامبهر لهبهردهست دادمهیت. پهیوهندی به ژماره تهلهفونی بێبهرامبهرهکهی سهس کارتی نهنامیهتی خۆت بکه

ພາຍເຫດສໍາຄັນ: ຖ້າທ່ານເວົ້າພາສາລາວ (**Lao**), ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີ ແລະ ການສື່ສານພຣີໃນຮູບແບບອື່ນໆໃຫ້ແກ່ທ່ານ, ເຊັ່ນ: ການພິມຂະຫນາດໃຫຍ່. ໂທຫາເບີໂທພຣີຢູ່ທີ່ບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

लक्ष्म्या: जर तुम्ही मराठी (**Marathi**) बोलत असल्यास, तर मोफत भाषा सहाय्य सेवा आणि इतर फॉर्मॅटमध्ये मोफत संप्रेषणे, जसे की मोठ्या प्रिंट, तुमच्यासाठी उपलब्ध आहेत. तुमच्या सदस्य ओळखपत्रावरील टोल फ्री क्रमांकावर कॉल करा.

Ñan: Ñe kwōj kenono **Kajin Majol (Marshallese)**, jibañ ko kōm maron im ejellok wonneir einwōt ukok im bōk melele ilo wāween ko jet, einwōt jeje ko relab, Kall ae nomba eo ejellok wonnen ebed itulikin kaat eo am.

BAA'ÁKONÍNÍZIN: Diné (Navajo) saad bee yáníłt'igo, t'áá jííł'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó nááná łahgo át'éego bee hadadilyaa bee ahíł hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nit'izí bee nééhoziní bąąh t'áá híik'eh bee hane'í námboo bee hodíłnih.

ध्यान दिनुहोस्: यदि तपाईंले नेपाली (**Nepali**) बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा निःशुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। आफ्नो सदस्य पहिचान कार्डमा रहेको टोल फ्री नम्बरमा कल गर्नुहोस्।

OBS: Hvis du snakker **norsk (Norwegian)**, er gratis språkhjelpstjenester og gratis kommunikasjon i andre formater, for eksempel stor skrift, tilgjengelig for deg. Ring gratisnummeret som du finner på medlemskortet ditt.

XIYYEEFFANNOO: Yoo Afaan Oromoo (**Oromo**) dubbattu ta'e, tajaajilootni deeggarsa afaanii bilisaa fi waliin dubbiin bilisaa kan akka maxxansa gurguddaa afaan keessaniin ni jiraatu. Lakkoofsa bilbila bilisaa kaardii miseensummaa keessan irra jiru irratti bilbilaa.

GEB ACHT: Wann du **Deutsch (Pennsylvania Dutch)** schwetzscht, Schprooch Hilfe mitaus Koscht un Communications in annere Formats wie groosse Druck iss meeglich. Ruf die koschdelos Nummer uff dei Member Identification Kaart.

PAKAIR: Mah ke ese lokaian **Pohnpei (Pohnpeian)**, sahpis en sawas en lokaia oh mehn kapehse ni soangen mwohmw teikan kin sohte isepe, me duwehte inting lapala, kak kohda ohng kowe. Eker nempem ni sohte isepe me mih pohn noumw doaropwehn tohn pwihn ID.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

УВАГА: Якщо ви розмовляєте **українською (Ukrainian)**, вам надаються безкоштовні мовні послуги та безкоштовні повідомлення в інших форматах, наприклад, крупним шрифтом. Зателефонуйте за безкоштовним номером телефону, позначеним на Вашій ідентифікаційній картці.

زبان بولتے ہیں تو آپ کے لیے زبان کی معاون خدمات اور دیگر فارمیٹ میں مفت مواصلات، **(Urdu) توجہ دیں:** اگر آپ اردو جیسے بڑے پرنٹ، آپ کے لیے دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

LUU Ý: Nếu quý vị nói Tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ nhận dạng thành viên của quý vị.

ATENSYON: Kung ang imong sinultihan kay **Visayan (Visayan)**, libre nga mga serbisyo sa tabang sa pinulongan ug libre nga komunikasyon sa ubang mga pormat, sama sa dagkong print, available kanimo. Tawage ang toll-free nga numero sa imong identipikasyon nga kard sa miyembro.

אכטונג: אויב איר רעדט אידיש **(Yiddish)**, אומזיסטע שפראך הילף סערוויסעס און אומזיסטע קאמיוניקאציע אין אנדערע פארמאטן, ווי גרויסע אותיות זענען אוועילעבל פאר אייך. רופט די טאל פרייע נומער אויף אייער מעמבער אידענטיפיקאציע קארטל.

ÀKÍYÈSÍ: Tí o bá ń sọ **Yorùbá (Yoruba)**, àwọn isẹ àtìlẹ́yìn èdè ọfẹ àti àwọn ìbáńsọ̀rọ̀ nínú àwọn ìgúnregé, bí àwọn àtẹ̀jádé ńlá, wà fún ọ. Pe nọmbà tí kò nílò owó lóri káàdì ìdánimọ ọmọ ẹgbẹ ẹ.

Notice of Non-Discrimination

We¹ comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race color, national origin, age, disability or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, please call 1-866-633-2446 or the toll-free member phone number on your member ID card, TTY/RTT 711.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

If you need help filing a complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your member ID card, TTY/RTT 711.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

This notice is available at: <https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notice>

¹For purposes of this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

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

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, 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.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

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

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

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to

regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

- Any documentation or other written information to support your request for claim payment.

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 30 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MEDICAL INFORMATION PRIVACY NOTICE

Effective January 1, 2025:

We² are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice that is currently in effect.

The terms "information" or "health information" in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to confirm we are meeting our privacy obligations.

We may collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician

to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsor**, if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**; however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders**, we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as needed to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:
 3. Alcohol and Substance Use Disorder
 4. Biometric Information
 5. Child or Adult Abuse or Neglect, including Sexual Assault
 6. Communicable Diseases
 7. Genetic Information
 8. HIV/AIDS
 9. Mental Health
 10. Minors' Information
 11. Prescriptions
 12. Reproductive or Sexual Health
 13. Sexually Transmitted Diseases

We will follow the more stringent law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For more information on how to revoke your authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request the deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** To exercise any of your rights described above. Mail your written requests to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint or Grievance.** If you believe your privacy rights have been violated, you may file a complaint or grievance with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

²This Health Plan Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; First Risk Advisors, Inc.; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; Healthplex Insurance Company; HealthSmart Primary Care Clinics, LP; International Healthcare Services, Inc.; MAMSI Life and Health Insurance Company; Managed Care of North America, Inc.; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; New Orleans Regional Physician Hospital Organization, L.L.C.; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Network, Inc.; Preferred Care Network of Florida, Inc.; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral Health Plan, California; UHC of California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc.; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.;

UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025

We³ are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Managed Physical

Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.